Severe Emotional Disturbance (SED)
CRITERIA CHECKLIST

Severe Emotional Disturbance (SED) determination is based on the age of the individual, diagnoses, functional impairment or symptoms, and duration of the disorder. The child/adolescent must meet all of the following criteria:

☐ 1. **Age:**

☐ be a person under the age of 18;

OR

☐ be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services.

☐ 2. **Diagnoses:**

Must meet A *or* B.

☐ A. The child/adolescent has an emotional and/or behavioral disability that has been diagnosed through the classification system in the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*.

- Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system behavioral health services.

☐ B. The term "complex trauma" describes children's exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. [*Dear State Director letter*, July 11, 2013, from CMS, SAMHSA, ACF.] In order to qualify as a complex trauma diagnosis the child must have experienced one of the following traumatic events:

☐ Abandoned or neglected;

☐ Sexually abused;

☐ Sexually exploited;

☐ Physically abused;

☐ Emotionally abused; or

☐ Repeated exposure to domestic violence.

In addition to one of the qualifying traumatic events above, there must also be an ex parte order issued by the children's court or the district court which includes a sworn written statement of facts showing probable cause exists to believe that the child is abused or neglected and that custody is necessary.

☐ 3. **Functional Impairment:**

The child/adolescent must have a Functional Impairment in two of the listed capacities:

☐ *Functioning in self-care:*

Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

☐ *Functioning in community:*

Inability to maintain safety without assistance; a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement.

☐ *Functioning in social relationships:*

Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

☐ *Functioning in the family:*

Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified
by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, in- ability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- rarely or minimally seeking comfort in distress
- limited positive affect and excessive levels of irritability, sadness or fear
- disruptions in feeding and sleeping patterns
- failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- willingness to go off with an unfamiliar adult with minimal or no hesitation
- regression of previously learned skills

☐ *Functioning at school/work:*

Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

☐ 4. **Symptoms:**

Symptoms in one of the following groups:

☐ *Psychotic symptoms:*

Symptoms are characterized by defective or lost contact with reality, often with hallucinations or delusions.

☐ *Danger to self, others and property as a result of emotional disturbance:*

The individual is self-destructive, e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.

☐ *Mood and anxiety symptoms*

The disturbance is excessive and causes clinically significant distress and which substantially interferes with or limits the child's role or functioning in family, school, or community activities

☐ *Trauma symptoms:*

Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience
a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:

- a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns
- under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
- under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
- over-responsivity to sensations and become hyper-vigilant or demonstrate fear and panic from being overwhelmed
- episodes of recurrent flashbacks or dissociation that present as staring or freezing

☐ 5. **Duration:**

☐ The disability must be expected to persist for six months or longer.

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Neurodevelopmental Disorders	299.00	F84.0	Autism Spectrum Disorder
Neurodevelopmental Disorders	307.22	F95.1	Motor Disorder – Persistent (chronic) Motor or Vocal Tic Disorder
Neurodevelopmental Disorders	307.23	F95.2	Tourette's Disorder
Neurodevelopmental Disorders	307.3	F98.4	Stereotypic Movement Disorder
Neurodevelopmental Disorders	314.00	F90.0	Attention –Deficit/Hyperactivity Disorder: Predominantly inattentive presentation
Neurodevelopmental Disorders	314.01	F90.1	Attention –Deficit/Hyperactivity Disorder: Predominantly hyperactive/impulsive presentation
Neurodevelopmental Disorders	314.01	F90.2	Attention –Deficit/Hyperactivity Disorder: Combined presentation
Neurodevelopmental Disorders	314.01	F90.8	Attention –Deficit/Hyperactivity Disorder: Other Specified Attention –Deficit/Hyperactivity Disorder
Neurodevelopmental Disorders	314.01	F90.0	Attention –Deficit/Hyperactivity Disorder: Unidentified Attention –Deficit/Hyperactivity Disorder
Schizophrenia Spectrum and other Psychotic Disorders	293.81	F06.2	With delusions
Schizophrenia Spectrum and other Psychotic Disorders	293.82	F06.0	With hallucinations
Schizophrenia Spectrum and other Psychotic Disorders	295.40	F20.81	Schizophreniform Disorder
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.0	Bipolar type
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.1	Depressive type

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Schizophrenia Spectrum and other Psychotic Disorders	295.90	F20.9	Schizophrenia
Schizophrenia Spectrum and other Psychotic Disorders	297.1	F22	Delusional Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia Spectrum and other Psychotic Disorders	293.89	F06.01	Catatonia Associated with Another Mental Disorder or Unspecified Catatonia
Schizophrenia Spectrum and other Psychotic Disorders	298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
Schizophrenia Spectrum and other Psychotic Disorders	301.22	F21	Schizotypal (Personality) Disorder
Bipolar and Related Disorders	293.83	F06.33	Bipolar and Related Disorders due to another medical condition. Specify: With manic features or with manic hypomanic-like episode
Bipolar and Related Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical condition– With mixed features
Bipolar and Related Disorders	296.40	F31.9	Unspecified
Bipolar and Related Disorders	296.41	F31.11	Mild
Bipolar and Related Disorders	296.42	F31.12	Moderate
Bipolar and Related Disorders	296.43	F31.13	Severe
Bipolar and Related Disorders	296.44	F31.2	With psychotic features
Bipolar and Related Disorders	296.45	F31.73	In partial remission
Bipolar and Related Disorders	296.46	F31.74	In full remission
Bipolar and Related Disorders	296.50	F31.9	Unspecified
Bipolar and Related Disorders	296.51	F31.31	Mild
Bipolar and Related Disorders	296.52	F31.32	Moderate
Bipolar and Related Disorders	296.53	F31.4	Severe
Bipolar and Related Disorders	296.54	F31.5	With psychotic features
Bipolar and Related Disorders	296.55	F31.75	In partial remission
Bipolar and Related Disorders	296.56	F31.76	In full remission
Bipolar and Related Disorders	296.89	F31.81	Bipolar II Disorder
Bipolar and Related Disorders	296.80	F31.9	Unspecified Bipolar and related disorder

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Depressive Disorders	296.99	F34.8	Disruptive Mood Dysregulation Disorder
Depressive Disorders	293.83	F06.31	Bipolar and Related Disorders Due to Another Medical Condition (80)–with depressive features
Depressive Disorders	293.83	F06.32	Bipolar and Related Disorders Due to Another Medical Condition (80) -with major depressive-like episodes
Depressive Disorders	293.83	F06.34	Bipolar and Related Disorders Due to Another Medical Condition (80) – with mixed features
Depressive Disorders	296.20	F32.9	Unspecified
Depressive Disorders	296.21	F32.0	Mild
Depressive Disorders	296.22	F32.1	Moderate
Depressive Disorders	296.23	F32.2	Severe
Depressive Disorders	296.24	F32.3	With psychotic features
Depressive Disorders	296.25	F32.4	In partial remission
Depressive Disorders	296.26	F32.5	In full remission
Depressive Disorders	296.30	F33.9	Unspecified
Depressive Disorders	296.31	F33.0	Mild
Depressive Disorders	296.32	F33.1	Moderate
Depressive Disorders	296.33	F33.2	Severe
Depressive Disorders	296.34	F33.3	With psychotic features
Depressive Disorders	296.35	F33.41	In partial remission
Depressive Disorders	296.36	F33.42	In full remission
Depressive Disorders	300.4	F34.1	Persistent Depressive Disorder
Depressive Disorders	311	F32.8	Other Specified Depressive Disorder
Depressive Disorders	311	F32.9	Unspecified Depressive Disorder
Depressive Disorders	625.4	N94.3	Premenstrual Dysphoric Disorder
Anxiety Disorders	293.84	F06.4	Anxiety Disorder Due to Another Medical Condition
Anxiety Disorders	300.00	F41.9	Unspecified Anxiety Disorder
Anxiety Disorders	300.01	F41.0	Panic Disorder
Anxiety Disorders	300.02	F41.1	Generalized Anxiety Disorder
Anxiety Disorders	300.09	F43.9	Other Specified Anxiety Disorder
Anxiety Disorders	300.22	F40.00	Agoraphobia
Anxiety Disorders	300.23	F40.10	Social Anxiety Disorder (Social Phobia)
Anxiety Disorders	309.21	F93.0	Separation Anxiety Disorder
Obsessive-Compulsive Related Disorders	294.8	F06.8	Obsessive-Compulsive Disorder Due to Another Medical Condition

Sources*: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Obsessive-Compulsive Related Disorders	300.3	F42	Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified Obsessive-Compulsive Related Disorder, Unspecified Obsessive-Compulsive Related Disorder
Obsessive-Compulsive Related Disorders	300.7	F45.22	Body Dysmorphic Disorder
Obsessive-Compulsive Related Disorders	312.39	F63.3	Trichotillomania (Hair-Pulling Disorder)
Obsessive-Compulsive Related Disorders	698.4	L98.1	Excoriation (Skin-Picking) Disorder
Trauma-and Stressor Related Disorders	308.3	F43.0	Acute Stress Disorder
Trauma-and Stressor Related Disorders	309.0	F43.21	With depressed mood
Trauma-and Stressor Related Disorders	309.24	F43.22	With anxiety
Trauma-and Stressor Related Disorders	309.28	F43.23	With anxiety and depressed mood
Trauma-and Stressor Related Disorders	309.3	F43.24	With disturbance of conduct
Trauma-and Stressor Related Disorders	309.4	F43.25	With mixed disturbance of emotions and conduct
Trauma-and Stressor Related Disorders	309.81	F43.10	Posttraumatic Stress Disorder
Trauma-and Stressor Related Disorders	309.89	F43.8	Other Specified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	309.9	F43.9	Unspecified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.1	Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.2	Disinhibited Social Engagement Disorder
Dissociative Disorders	300.12	F44.0	Dissociative Amnesia
Dissociative Disorders	300.13	F44.1	With dissociative fugue
Dissociative Disorders	300.14	F44.81	Dissociative Identity Disorder
Dissociative Disorders	300.15	F44.89	Other Specified Dissociative Disorder
Dissociative Disorders	300.15	F44.9	Unspecified Dissociative Disorder
Dissociative Disorders	300.6	F48.1	Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders	300.11	F44.4	Conversation Disorder (Functional Neurological Symptom Disorder. Specify: with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders	300.11	F44.5	Conversation Disorder (Functional Neurological Symptom)Disorder. Specify: with attacks of seizures; or with special sensory loss

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Somatic Symptom and Related Disorders	300.11	F44.6	Conversation Disorder (Functional Neurological Symptom Disorder –with anesthesia or sensory loss)
Somatic Symptom and Related Disorders	300.11	F44.7	Conversation Disorder (Functional Neurological Symptom Disorder – with mixed symptoms)
Somatic Symptom and Related Disorders	300.19	F68.10	Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another
Somatic Symptom and Related Disorders	300.7	F45.21	Illness Anxiety Disorder
Somatic Symptom and Related Disorders	300.82	F45.1	Somatic Symptom Disorder
Somatic Symptom and Related Disorders	300.89	F45.8	Other Specified Somatic Symptom and Related Disorders
Feeding and Eating Disorders	307.1	F50.01	Anorexia Nervosa - Restricting type
Feeding and Eating Disorders	307.1	F50.02	Anorexia Nervosa– Binge-eating/Purging type
Feeding and Eating Disorders	307.50	F50.9	Unspecified Feeding and Eating Disorders
Feeding and Eating Disorders	307.51	F50.2 F50.8	Bulimia Nervosa (F50.2) Binge-eating Disorder (F50.)
Feeding and Eating Disorders	307.52	F98.3	In children
Feeding and Eating Disorders	307.52	F50.8	In adults
Disruptive, Impulse Control and Conduct Disorders	312.33	F63.1	Pyromania
Disruptive, Impulse Control and Conduct Disorders	312.34	F63.81	Intermittent Explosive Disorder
Disruptive, Impulse Control and Conduct Disorders	312.81	F91.1	Childhood-onset type
Disruptive, Impulse Control and Conduct Disorders	312.89	F91.8	Other Specified Disruptive Impulse-Control, and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	312.9	F91.9	Unspecified Disruptive, Impulse Control and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	313.81	F91.3	Oppositional Defiant Disorder – Specify current severity: Mild, Moderate, Severe
Cyclothymic Disorder	301.13	F34.0	Cyclothymic Disorder
Persistent Depressive Disorder	300.4	F34.1	Persistent Depressive Disorder - Dysthymia
Personality Disorders [For which there is an evidence based clinical intervention available] for SMI	301.83	F60.3	Borderline Personality Disorder

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix B
Substance Use Disorder (SUD) Criteria

SUD Criteria	DSM-V ICD-9	DSM-V ICD-10	Description
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate, Severe
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder - Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate, Severe
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or unspecified stimulant
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder- Other Hallucinogen Use Disorder - Moderate , Severe
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder –Phencyclidine Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown)Substance-Related and Addictive Disorders - Moderate, Severe

Sources*: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document,* and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Serious Mental Illness (SMI)
CRITERIA CHECKLIST

Serious Mental Illness (SMI) determination is based on the age of the individual, functional impairment, duration of the disorder and the diagnosis. Adults must meet all of the following four criteria:

☐ 1. **Age:** Must be an adult 18 years of age or older.

☐ 2. **Diagnoses:** Have one of the diagnoses as defined under the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*. The diagnosis would need to have been determined within the prior 12 months by an appropriately credentialed and licensed professional.

- Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system behavioral health services.

☐ 3. **Functional Impairment:** The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

☐ 4. **Duration:**

☐ The disability must be expected to persist for six months or longer.

Person must meet SMI criteria and at least one of the following in A or B:

☐ A. Symptom Severity and Other Risk Factors

☐ Significant current danger to self or others or presence of active symptoms of a SMI.
☐ Three or more emergency room visits or at least one psychiatric hospitalization within the last year.
☐ Individuals with substance use disorder that complicates SMI and results in worsened intoxicated/withdrawal complications, bio medical conditions, emotional/behavior/cognitive conditions.
☐ Person is experiencing trauma symptoms related to sexual assault, domestic violence or other traumatic event.

☐ B. Co-Occurring Disorders

☐ Substance Use Disorder (SUD) diagnosis and any mental illness that affects functionality.
☐ SMI or SUD and potentially life-threatening chronic medical condition (e.g., diabetes, HIV/AIDS, hepatitis).
☐ SMI or SUD and Developmental Disability.

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Neurodevelopmental Disorders	299.00	F84.0	Autism Spectrum Disorder
Neurodevelopmental Disorders	307.22	F95.1	Motor Disorder – Persistent (chronic) Motor or Vocal Tic Disorder
Neurodevelopmental Disorders	307.23	F95.2	Tourette's Disorder
Neurodevelopmental Disorders	307.3	F98.4	Stereotypic Movement Disorder
Neurodevelopmental Disorders	314.00	F90.0	Attention –Deficit/Hyperactivity Disorder: Predominantly inattentive presentation
Neurodevelopmental Disorders	314.01	F90.1	Attention –Deficit/Hyperactivity Disorder: Predominantly hyperactive/impulsive presentation
Neurodevelopmental Disorders	314.01	F90.2	Attention –Deficit/Hyperactivity Disorder: Combined presentation
Neurodevelopmental Disorders	314.01	F90.8	Attention –Deficit/Hyperactivity Disorder: Other Specified Attention –Deficit/Hyperactivity Disorder
Neurodevelopmental Disorders	314.01	F90.0	Attention –Deficit/Hyperactivity Disorder: Unidentified Attention –Deficit/Hyperactivity Disorder
Schizophrenia Spectrum and other Psychotic Disorders	293.81	F06.2	With delusions
Schizophrenia Spectrum and other Psychotic Disorders	293.82	F06.0	With hallucinations
Schizophrenia Spectrum and other Psychotic Disorders	295.40	F20.81	Schizophreniform Disorder
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.0	Bipolar type
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.1	Depressive type

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Schizophrenia Spectrum and other Psychotic Disorders	295.90	F20.9	Schizophrenia
Schizophrenia Spectrum and other Psychotic Disorders	297.1	F22	Delusional Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia Spectrum and other Psychotic Disorders	293.89	F06.01	Catatonia Associated with Another Mental Disorder or Unspecified Catatonia
Schizophrenia Spectrum and other Psychotic Disorders	298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
Schizophrenia Spectrum and other Psychotic Disorders	301.22	F21	Schizotypal (Personality) Disorder
Bipolar and Related Disorders	293.83	F06.33	Bipolar and Related Disorders due to another medical condition. Specify: With manic features or with manic hypomanic-like episode
Bipolar and Related Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical condition– With mixed features
Bipolar and Related Disorders	296.40	F31.9	Unspecified
Bipolar and Related Disorders	296.41	F31.11	Mild
Bipolar and Related Disorders	296.42	F31.12	Moderate
Bipolar and Related Disorders	296.43	F31.13	Severe
Bipolar and Related Disorders	296.44	F31.2	With psychotic features
Bipolar and Related Disorders	296.45	F31.73	In partial remission
Bipolar and Related Disorders	296.46	F31.74	In full remission
Bipolar and Related Disorders	296.50	F31.9	Unspecified
Bipolar and Related Disorders	296.51	F31.31	Mild
Bipolar and Related Disorders	296.52	F31.32	Moderate
Bipolar and Related Disorders	296.53	F31.4	Severe
Bipolar and Related Disorders	296.54	F31.5	With psychotic features
Bipolar and Related Disorders	296.55	F31.75	In partial remission
Bipolar and Related Disorders	296.56	F31.76	In full remission
Bipolar and Related Disorders	296.89	F31.81	Bipolar II Disorder
Bipolar and Related Disorders	296.80	F31.9	Unspecified Bipolar and related disorder

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Depressive Disorders	296.99	F34.8	Disruptive Mood Dysregulation Disorder
Depressive Disorders	293.83	F06.31	Bipolar and Related Disorders Due to Another Medical Condition (80)–with depressive features
Depressive Disorders	293.83	F06.32	Bipolar and Related Disorders Due to Another Medical Condition (80) -with major depressive-like episodes
Depressive Disorders	293.83	F06.34	Bipolar and Related Disorders Due to Another Medical Condition (80) – with mixed features
Depressive Disorders	296.20	F32.9	Unspecified
Depressive Disorders	296.21	F32.0	Mild
Depressive Disorders	296.22	F32.1	Moderate
Depressive Disorders	296.23	F32.2	Severe
Depressive Disorders	296.24	F32.3	With psychotic features
Depressive Disorders	296.25	F32.4	In partial remission
Depressive Disorders	296.26	F32.5	In full remission
Depressive Disorders	296.30	F33.9	Unspecified
Depressive Disorders	296.31	F33.0	Mild
Depressive Disorders	296.32	F33.1	Moderate
Depressive Disorders	296.33	F33.2	Severe
Depressive Disorders	296.34	F33.3	With psychotic features
Depressive Disorders	296.35	F33.41	In partial remission
Depressive Disorders	296.36	F33.42	In full remission
Depressive Disorders	300.4	F34.1	Persistent Depressive Disorder
Depressive Disorders	311	F32.8	Other Specified Depressive Disorder
Depressive Disorders	311	F32.9	Unspecified Depressive Disorder
Depressive Disorders	625.4	N94.3	Premenstrual Dysphoric Disorder
Anxiety Disorders	293.84	F06.4	Anxiety Disorder Due to Another Medical Condition
Anxiety Disorders	300.00	F41.9	Unspecified Anxiety Disorder
Anxiety Disorders	300.01	F41.0	Panic Disorder
Anxiety Disorders	300.02	F41.1	Generalized Anxiety Disorder
Anxiety Disorders	300.09	F43.9	Other Specified Anxiety Disorder
Anxiety Disorders	300.22	F40.00	Agoraphobia
Anxiety Disorders	300.23	F40.10	Social Anxiety Disorder (Social Phobia)
Anxiety Disorders	309.21	F93.0	Separation Anxiety Disorder
Obsessive-Compulsive Related Disorders	294.8	F06.8	Obsessive-Compulsive Disorder Due to Another Medical Condition

Sources*: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Obsessive-Compulsive Related Disorders	300.3	F42	Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified Obsessive-Compulsive Related Disorder, Unspecified Obsessive-Compulsive Related Disorder
Obsessive-Compulsive Related Disorders	300.7	F45.22	Body Dysmorphic Disorder
Obsessive-Compulsive Related Disorders	312.39	F63.3	Trichotillomania (Hair-Pulling Disorder)
Obsessive-Compulsive Related Disorders	698.4	L98.1	Excoriation (Skin-Picking) Disorder
Trauma-and Stressor Related Disorders	308.3	F43.0	Acute Stress Disorder
Trauma-and Stressor Related Disorders	309.0	F43.21	With depressed mood
Trauma-and Stressor Related Disorders	309.24	F43.22	With anxiety
Trauma-and Stressor Related Disorders	309.28	F43.23	With anxiety and depressed mood
Trauma-and Stressor Related Disorders	309.3	F43.24	With disturbance of conduct
Trauma-and Stressor Related Disorders	309.4	F43.25	With mixed disturbance of emotions and conduct
Trauma-and Stressor Related Disorders	309.81	F43.10	Posttraumatic Stress Disorder
Trauma-and Stressor Related Disorders	309.89	F43.8	Other Specified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	309.9	F43.9	Unspecified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.1	Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.2	Disinhibited Social Engagement Disorder
Dissociative Disorders	300.12	F44.0	Dissociative Amnesia
Dissociative Disorders	300.13	F44.1	With dissociative fugue
Dissociative Disorders	300.14	F44.81	Dissociative Identity Disorder
Dissociative Disorders	300.15	F44.89	Other Specified Dissociative Disorder
Dissociative Disorders	300.15	F44.9	Unspecified Dissociative Disorder
Dissociative Disorders	300.6	F48.1	Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders	300.11	F44.4	Conversation Disorder (Functional Neurological Symptom Disorder. Specify: with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders	300.11	F44.5	Conversation Disorder (Functional Neurological Symptom)Disorder. Specify: with attacks of seizures; or with special sensory loss

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Somatic Symptom and Related Disorders	300.11	F44.6	Conversation Disorder (Functional Neurological Symptom Disorder –with anesthesia or sensory loss)
Somatic Symptom and Related Disorders	300.11	F44.7	Conversation Disorder (Functional Neurological Symptom Disorder – with mixed symptoms)
Somatic Symptom and Related Disorders	300.19	F68.10	Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another
Somatic Symptom and Related Disorders	300.7	F45.21	Illness Anxiety Disorder
Somatic Symptom and Related Disorders	300.82	F45.1	Somatic Symptom Disorder
Somatic Symptom and Related Disorders	300.89	F45.8	Other Specified Somatic Symptom and Related Disorders
Feeding and Eating Disorders	307.1	F50.01	Anorexia Nervosa - Restricting type
Feeding and Eating Disorders	307.1	F50.02	Anorexia Nervosa– Binge-eating/Purging type
Feeding and Eating Disorders	307.50	F50.9	Unspecified Feeding and Eating Disorders
Feeding and Eating Disorders	307.51	F50.2 F50.8	Bulimia Nervosa (F50.2) Binge-eating Disorder (F50.)
Feeding and Eating Disorders	307.52	F98.3	In children
Feeding and Eating Disorders	307.52	F50.8	In adults
Disruptive, Impulse Control and Conduct Disorders	312.33	F63.1	Pyromania
Disruptive, Impulse Control and Conduct Disorders	312.34	F63.81	Intermittent Explosive Disorder
Disruptive, Impulse Control and Conduct Disorders	312.81	F91.1	Childhood-onset type
Disruptive, Impulse Control and Conduct Disorders	312.89	F91.8	Other Specified Disruptive Impulse-Control, and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	312.9	F91.9	Unspecified Disruptive, Impulse Control and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	313.81	F91.3	Oppositional Defiant Disorder – Specify current severity: Mild, Moderate, Severe
Cyclothymic Disorder	301.13	F34.0	Cyclothymic Disorder
Persistent Depressive Disorder	300.4	F34.1	Persistent Depressive Disorder - Dysthymia
Personality Disorders [For which there is an evidence based clinical intervention available] for SMI	301.83	F60.3	Borderline Personality Disorder

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix B
Substance Use Disorder (SUD) Criteria

SUD Criteria	DSM-V ICD-9	DSM-V ICD-10	Description
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate, Severe
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder - Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate, Severe
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or unspecified stimulant
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder- Other Hallucinogen Use Disorder - Moderate , Severe
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder –Phencyclidine Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown)Substance-Related and Addictive Disorders - Moderate, Severe

Sources*: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document,* and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Trauma-Informed Care IC
Performance Monitoring Tool (PMT)

Tracking progress is an important part of systems change. In order to be successful; primary care organizations should have a clear understanding of where they are starting, where they want to go, and tools to measure their progress along the way. This allows team members and others interested in the work to remain enthusiastic and to determine what is working and what is not. It creates the opportunity for the team to regroup, refocus and monitor momentum. This simple tool is one way to stay on track.

Your team will submit the Performance Monitoring Tool (PMT) to your National Council faculty lead two times during the duration of the Innovation Community. Once submitted; your faculty lead will schedule a team call to review your progress, help you think through your next steps and address any challenges your team might be facing.

Contact Information

Name of Organization_____

Your Name_____

Your E-Mail_____

Date of Submission_____

INFRASTRUCTURE DEVELOPMENT

1. Does your Core Implementation Team (CIT) continue to meet at least twice each month?
   - ☐ NO
   - ☐ YES

   If yes, how often does the CIT meet? _____

   How long does the CIT meet? _____

2. Do you have a larger oversight team or committee that supports Trauma-Informed Care (TIC)?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

   If yes, how often do they meet? _____

   Who is on the oversight team?

3. Has your organization expanded the number of staff members involved in TIC related workgroups beyond the CIT? (e.g., domain specific workgroups)
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

   If yes, describe your efforts to expand the number of staff members involved in TIC workgroups or teams:

Additional accomplishments, key challenges and future plans related to infrastructure:

Domain 1: EARLY SCREENING AND COMPREHENSIVE ASSESSMENT

1. Are Medical History/Health Forms or Trauma Screening Tools used to routinely screen for trauma?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

   If yes, what type of instrument do you use? _____

   How many clients were screened for trauma? _____

   How many clients screened positive for trauma? _____

2. Has your medical staff been trained to screen for trauma in a competent and sensitive manner and assist clients to make the connection between trauma and PH/MH/SA concerns?
   - ☐ No
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

   If yes, how many staff members have been trained? _____

3. Is there a system in place to periodically re-screen clients who were initially screened as having none to few adverse life events?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

   If yes, when is this done? Individual BH Sessions_____ Primary Care Visit_____

   Other_____

4. Is there a system in place to immediately respond to reports of current and harmful adverse life experiences such as domestic violence or community violence?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

5. Are clients who have received a positive assessment of trauma engaged in considering brief or longer term trauma-specific services provided by the health center or an external provider?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

   If yes, which of the following processes/treatments do you use?

   Internal Referral _____ External Referral _____ Brief TX _____ Long Term TX_____

6. For those clients needing referral to internal or external BH services, is a staff member identified to monitor the referral process until the client keeps their first appointment?

☐ NO

☐ YES (we started this prior to the Learning Community)

☐ YES (we started/expanded this since we joined this Learning Community)

If yes, what is the title of the person monitoring this process?

_____

What is the number of appointments that have been kept through this process? _____

Additional accomplishments, key challenges and future plans related to this domain:

Domain 2: CLIENT VOICE, CHOICE AND COLLABORATION

1. Is there a system in place to collect, analyze, and utilize client satisfaction and perception of care including feedback related to physical and emotional safety?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

   If yes, what tools have been used?

   _____

   How often is feedback collected?

   _____

2. Are recipients of care involved in organizational meetings that influence decisions? (Check all that apply)
   - ☐ NO
   - ☐ YES

   If yes, which of the following applies? Advisory councils/boards/committees _____

   Formal Focus Groups_____ Other: _____

3. Are information and education provided to clients to explain the impact of adverse life events on a person's whole health?
   (Check all that apply)
   - ☐ Trauma-specific informational brochures
   - ☐ Trauma informational poster
   - ☐ Trauma education groups
   - ☐ Other: _____

Additional accomplishments, key challenges and future plans related to this domain:

Domain 3: WORKFORCE DEVELOPMENT AND BEST PRACTICES

1. Do all levels of staff receive education about their role in promoting safe and healing relationships through an in-service program and/or external opportunities designed to increase staff skills and knowledge of trauma and trauma informed/sensitive practices?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

     If yes, how many staff members have been trained? _____

2. Do behavioral health and primary care specialists receive education and training on sensitive screening and assessment practices and procedures?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

     If yes, how many staff members have been trained? _____

3. Do on-site behavioral health specialists receive education and training to ensure that they are equipped to deliver brief, evidence-informed individual and group treatment interventions?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

     If yes, what types of training have been received? _____

4. Have all new and current employees received training on trauma informed care principles and practices?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

5. Is a process in place to engage in client-centered, shared care planning between disciplines?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

6. Does a strong system of collaboration, communication, and team-based, client-centered, coordinated care exist between behavioral health and primary care staff?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

     If yes, what process is this done through (check all that apply):
     - ☐ Cross training
     - ☐ Informal/formal meetings
     - ☐ Team huddles
     - ☐ Other _____

7. Is a system in place to educate all staff about compassion fatigue, secondary traumatization, and burnout?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

     If yes, how many trainings have been held on these topics? _____

8. Are policies and procedures in place to address staff wellness?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

     If yes, what types of wellness policies have been developed? _____

Additional accomplishments, key challenges and future plans related to this domain:

Domain 4: SAFE AND SECURE ENVIRONMENT

1. Do all levels of staff receive education about their role in promoting safe and healing relationships?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

2. Is a system in place to monitor and evaluate changes made to the environment that promote safety and comfort?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)
     If yes, list changes made to the environment: _____

3. Is a system in place to assess and address environmental concerns that may affect safety, security, comfort and respect for both clients and staff?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)
     If yes, what types of assessments have been used? _____

Additional accomplishments, key challenges and future plans related to this domain:

Domain 5: DATA COLLECTION AND PERFORMANCE IMPROVEMENT

1. Is a system in place to track and analyze performance on one or more trauma-informed care domains in a way that effectively addresses challenges and reinforces progress?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

2. Is a system is in place to collect, analyze, and utilize data designed to assess the degree to which the organization is accomplishing its aims related to adopting the principles and practices of trauma-informed care?
   - ☐ NO
   - ☐ YES (we started this prior to the Learning Community)
   - ☐ YES (we started/expanded this since we joined this Learning Community)

     If yes, through which of the following methods is data collected?

     EHR _____Electronic Registries _____ Manual Tracking Logs _____

3. Data collected includes which of the following?

   (Check all that apply)
   - ☐ Number of clients screened for trauma
   - ☐ Number of clients with positive screen for trauma
   - ☐ Number of clients with a positive screen that receive a comprehensive trauma assessment
   - ☐ Number of clients referred to on-site trauma-specific services (individual and/or group)
   - ☐ Number of clients referred to off-site r trauma specific services (individual and/or group)
   - ☐ Number of clients who accept referral and attend trauma specific services
   - ☐ Pre and post survey of clients experience of onsite trauma-specific services
   - ☐ Client health outcomes specific to the needs of the population served

Additional accomplishments, key challenges and future plans related to this domain:

Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol

Community Connections; Washington, D.C.
Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.

April, 2009

Introduction

Over the past fifteen years, there has been growing acknowledgement of several interrelated facts concerning the prevalence and impact of trauma in the lives of people in contact with various human service systems. We advocate for trauma-informed service approaches for a number of reasons.

- **Trauma is pervasive.** National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event. And individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes. The experience of trauma is simply not the rare exception we once considered it. It is part and parcel of our social reality.

- **The impact of trauma is very broad and touches many life domains.** Trauma exposure increases the risk of a tremendous range of vulnerabilities: mental health problems like posttraumatic stress disorder, depression, excessive hostility, and generalized anxiety; substance abuse; physical health problems; interpersonal struggles; eating disorders; and suicidality, among many others. Trauma thus touches many areas of life not obviously or readily connected with the experience of trauma itself. This broad impact makes it particularly important to understand the less evident links between trauma and its sequelae.

- **The impact of trauma is often deep and life-shaping.** Trauma can be fundamentally life-altering, especially for those individuals who have faced repeated and prolonged abuse and especially when the violence is perpetrated by those who were supposed to be caretakers. Physical, sexual, and emotional violence become a central reality around which profound neurobiological and psychosocial adaptations occur. Survivors may come to see themselves as fundamentally flawed and to perceive the world as a pervasively dangerous place. Trauma may shape a person's way of viewing and being in the world; it can deflate the spirit and trample the soul.

- **Violent trauma is often self-perpetuating.** Individuals who are victims of violence are at increased risk of becoming perpetrators themselves. The intergenerational transmission of violence is well documented. Community violence is often built around cycles of retaliation. Many of our institutions—criminal justice settings, certainly, but also schools and churches and hospitals—are too frequently places where violent trauma is perpetuated rather than eliminated.

•**Trauma is insidious and preys particularly on the more vulnerable among us.** People who are poor, who are homeless, who have been diagnosed with severe mental health problems, who are addicted to drugs, or who have developmental disabilities—all of these groups are at increased risk of violent victimization.

•**Trauma affects the way people approach potentially helpful relationships.** Not surprisingly, those individuals with histories of abuse are often reluctant to engage in, or quickly drop out of, many human services. Being vigilant and suspicious are often important and thoroughly understandable self-protective mechanisms in coping with trauma exposure. But these same ways of coping may make it more difficult for survivors to feel the safety and trust necessary to helpful relationships.

•**Trauma has often occurred in the service context itself.** Involuntary and physically coercive practices, as well as other activities that trigger trauma-related reactions, are still too common in our centers of help and care.

•**Trauma affects staff members as well as consumers in human services programs.** Stressors deeply affect administrators, clinicians, and support staff working in human services. Not only is "secondary" or "vicarious" traumatization common but direct threats to physical and emotional safety are also frequent concerns. Being asked to do "more and more with less and less" becomes a pervasive theme underlying work experiences that may threaten to overwhelm coping abilities.

Growing awareness of these facts regarding trauma has led to calls for the development of both trauma-informed and trauma-specific services. Human service systems become **trauma-informed** by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to avoid retraumatizing those who come seeking assistance as well as staff working in service settings. These services seek "safety first" and commit themselves to "do no harm." The SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study (1998-2003) has provided evidence that trauma-informed approaches can enhance the effectiveness of mental health and substance abuse services. By contrast, **trauma-specific services** have a more focused primary task: to directly address trauma and its impact and to facilitate trauma recovery. An increasing number of promising and evidence-based practices address PTSD and other consequences of trauma, especially for people who often bring other complicating vulnerabilities (e.g., substance use, severe mental health problems, homelessness, contact with the criminal justice system) to the service setting.

This Self-Assessment and Planning Protocol and its accompanying CCTIC Program Self-Assessment Scale attempt to provide clear, consistent guidelines for agencies or programs interested in facilitating trauma-informed modifications in their service systems. It is a tool for administrators, providers, and survivor-consumers to use in the development, implementation, evaluation, and ongoing monitoring of trauma-informed programs.

Overview of the Change Process, Protocol, and Scale

Culture Change in Human Service Programs

The Creating Cultures of Trauma-Informed Care approach to organizational change is built on five core values of **safety, trustworthiness, choice, collaboration, and empowerment**. If a program can say that its **culture** reflects each of these values in each contact, physical setting, relationship, and activity and that this culture is evident in the experiences of staff as well as consumers, then the program's culture is trauma-informed.

We emphasize organizational culture because it represents the most inclusive and general level of an agency or program's fundamental approach to its work. Organizational culture reflects what a program considers important and unimportant, what warrants attention, how it understands the people it serves and the people who serve them, and how it puts these understandings into daily practice. In short, culture expresses the basic values of a program. Culture thus extends well beyond the introduction of new services or the training of a particular subset of staff members; it is pervasive, including all aspects of an agency's functioning.

In order to accomplish this culture change, we strongly recommend several steps:

1) Initial Planning. In this phase, the program considers the importance of, and weighs its commitment to, a trauma-informed change process. The following elements are key to the successful planning of organizational trauma-informed change: a) administrative commitment to and support of the initiative (see Domain 4 below); b) the formation of a trauma initiative workgroup to lead and oversee the change process; c) the full representation of each significant stakeholder group on the workgroup—administrators, supervisors, direct service staff, support staff, and consumers; d) identification of trauma "champions" to keep the initiative alive and "on the front burner;" e) programmatic awareness of the scope (the entire agency and its culture) and timeline (one to two years) of the culture shift.

Discussions of trauma-informed program modifications constitute an opportunity to involve <u>all</u> key groups in the review and planning process. In our experience, the more inclusive and fully representative these discussions are, the more effective and substantial the resulting changes.

2) A Kickoff Training Event. Usually two days long, the kickoff training is attended by as many of the staff as practical and includes significant consumer representation; it certainly includes all members of the trauma initiative workgroup. During this event, there are at least three presentations. In the first, central ideas of trauma-informed cultures are presented, emphasizing shifts in both understanding and in practice. In addition, the importance of staff support and care is emphasized. Finally, a third presentation addresses the importance of trauma in the work of the specific agency (e.g., trauma and substance use, trauma and children or youth, trauma and mental health problems). There is also a great deal of time for the workgroup members and other attendees to discuss the planning process in more detail and to conduct preliminary conversations that will mirror those to be held in the larger agency after the kickoff. The goal of the kickoff is to motivate and energize the change process while simultaneously

providing a beginning sense of direction. The kickoff ends with discussion of next steps in the implementation of this change initiative.

3) Short-term Follow-up. Over the next several months, the agency takes the ideas from the training and applies them in more detail, using this Self-Assessment and Planning Protocol. First, the workgroup develops an Implementation Plan for review by the rest of the administration, staff, and consumers, as well as by outside consultants with experience in facilitating agency change. Community Connections consultants, for example, provide detailed feedback on Implementation Plans; discuss any barriers as they arise; and assist in developing strategies to overcome these obstacles. Simultaneously, two educational events are scheduled for all staff. The first is on Understanding Trauma or Trauma 101. This training is designed to discuss the prevalence and impact of trauma as well as some of the multiple paths to recovery, emphasizing the ways in which trauma may be seen in the lives of consumers and in the work experience of staff. The second training focuses more directly on Staff Support and Care, emphasizing that a culture shift toward a trauma-informed system of care rests on staff members' experiences of safety, trustworthiness, choice, collaboration, and empowerment. Ideally, these training events are offered by experienced trainers who are also able and willing to encourage and teach staff members to become trainers themselves. In this way, as the program is able, its own trainers become equipped to pass along the important information about trauma to newer or untrained staff.

4) Longer-term Follow-up. After about six months, Community Connections consultants revisit the program site to meet with the workgroup and selected others, in order to review and discuss progress to date. At that time, ongoing processes may be put in place to sustain the initiative to its conclusion. For example, many agencies build trauma-informed questions into their Consumer Satisfaction Survey. Many add the Implementation Plans to the quality assurance or improvement process. Still others, in larger systems, discuss ways to build in consultation to their own and other agencies through a "train the consultant" approach. /The most important goal at this phase is to maintain the momentum established after the kickoff training until the culture change is thoroughgoing.

The CCTIC Self-Assessment and Planning Protocol

The Self-Assessment and Planning Protocol is divided into six domains; they address both services-level and administrative or systems-level changes. In each domain, there are guiding questions for a collaborative discussion by a comprehensive workgroup of a program's activities and physical settings, followed by a list of more specific questions and/or possible indicators of a trauma-informed approach. Many of these questions and indicators are drawn from the experiences of human service agencies that have previously engaged in this self-assessment.

The CCTIC Self-Assessment Scale

Following the questions and indicators are brief notes linking the Self-Assessment and Planning Protocol to the Trauma-Informed Self-Assessment Scale. The structure and format of the Program Self-Assessment Scale are similar to those of "fidelity scales" commonly used to

assess the extent to which a service model is actually being implemented as intended (e.g., consistent with a plan or a manual). Both administrative and clinical experience suggests that attributes of the system "as a whole" have a very significant impact on the implementation and potentially the effectiveness of any specific services offered. This instrument reflects current thinking about those program characteristics—at both the services and systems level—most likely to provide the sort of context in which people with trauma histories may become engaged in chosen services most helpful to their recovery.

The Self-Assessment Scale is intended primarily for the use of programs to assess their own current practices and/or to track their progress in relation to a specific understanding of trauma-informed services (Harris & Fallot, 2001). We recommend that programs beginning this review process complete the Scale at the time of their initial overall self-assessment. Its patterns may be helpful in prioritizing areas for change. Subsequent dates for completion of the Scale may be scheduled based on the key timelines in a trauma-informed Program Implementation Plan. Self-monitoring can therefore be built into the change process. Some programs may choose to have the assessment completed by raters from outside the program. Outside raters would need access to administrative and clinical records and also be able to conduct interviews, surveys, and/or focus groups as necessary to gain a complete picture of the agency's culture.

Part A: Services-level Changes

Domain 1. Program Procedures and Settings: "To what extent are program activities and settings consistent with five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment?"

This section of the protocol can be used to assess the extent to which formal and informal procedures and the physical environment in a human services program are trauma-informed and to plan corresponding modifications in service delivery practices. Consumer-survivors should be actively involved in the review process as should support staff, direct service staff, supervisors, and administrators.

Step One: Identify Key Formal and Informal Activities and Settings

The goal of Step One is to gain a comprehensive sense of the experiences of both consumers and staff members as they come to the setting and participate in its activities, relationships, and physical settings. The goal of this review is to capture for each of these groups—consumer and staff—their experiences *in detail* from their very first to their very last contact with the program or agency. Though some programs accomplish this effectively by forming a representative workgroup to review the full range of contacts, others have found it very helpful to engage in a "walk-through." A walk-through is a process in which staff members come to the setting "as if" they are new consumers and thus enter the setting with a consumer-oriented perspective. For more details about one way to conduct such a walk-through, see the NIATx website: www.niatx.net. Sites routinely begin by focusing on the experiences of consumers and then repeat the process for staff members.

A. List the sequence of service ***activities*** in which new consumers are usually involved (e.g., outreach, intake, assessment, service planning). Think broadly to include informal as well as formal contacts. For example, consumers may be greeted and given directions by a number of people prior to formal service delivery.

B. Identify the ***staff members*** (positions and individuals) who have contact with consumers at each point in this process.

C. Identify the ***settings*** in which the various activities are likely to take place (e.g., home, waiting room, telephone, office, institution).

Step Two: Ask Key Questions about Each of the Activities and Settings

(See list of questions for Domains 1A-1E following Step Four)

Step Three: Prioritize Goals for Change

After the workgroup has reviewed services and has developed a list of possible trauma-informed changes in service delivery procedures, these goals for change should be prioritized. Among the factors to consider in this prioritizing are the following: (1) feasibility (which goals are most

likely to be accomplished because of their scale and the kind of change involved?); (2) resources (which goals are most consistent with the financial, personal, and other resources available?); (3) system support (which goals have the most influential and widespread support?); (4) breadth of impact (which goals are most likely to have a broad impact on services?); (5) quality of impact (which goals will make the most difference in the lives of consumers?); (6) risks and costs of not changing (which practices, if not changed, will have the most negative impact?).

Step Four: Identify Specific Objectives and Responsible Persons

After goals have been prioritized, specific objectives (measurable outcomes with timelines for achievement) can be stated and persons responsible for implementing and monitoring the corresponding tasks can be named. These objectives are incorporated into the program's Implementation Plan.

Domain 1A. Safety—Ensuring Physical and Emotional Safety

♦ ***Key Questions: "To what extent do the program's activities and settings ensure the physical and emotional safety of consumers? How can services be modified to ensure this safety more effectively and consistently?"***

Sample Specific Questions:

- Where are services delivered?
- When are they delivered?
- Who is present (other consumers, etc.)? Are security personnel present? What impact do these others have?
- What signs are there? Are they welcoming? Clear? Legible?
- Are doors locked or open? Are there easily accessible exits?
- How would you describe the reception and waiting areas, interview rooms, etc.? Are they comfortable and inviting?
- Are restrooms easily accessible?
- Are the first contacts with consumers welcoming, respectful, and engaging?
- Do consumers receive clear explanations and information about each task and procedure? Are the rationales made explicit? Is the program mission explained? Are specific goals and objectives made clear? Does each contact conclude with information about what comes next?
- Are staff attentive to signs of consumer discomfort or unease? Do they understand these signs in a trauma-informed way?
- What events have occurred that indicate a lack of safety—physically or emotionally (e.g., arguments, conflicts, assaults)? What triggered these incidents? What alternatives could be put in place to minimize the likelihood of their recurrence?
- Is there adequate personal space for individual consumers?
- In making contact with consumers, is there sensitivity to potentially unsafe situations (e.g., domestic violence)?

Domain 1B. Trustworthiness—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

♦ ***Key Questions: "To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximize honesty and transparency?"***

Sample Specific Questions:

- Does the program provide clear information about what will be done, by whom, when, why, under what circumstances, at what cost, with what goals?
- When, if at all, do boundaries veer from those of the respectful professional? Are there pulls toward more friendly (personal information sharing, touching, exchanging home phone numbers, contacts outside professional appointments, loaning money, etc.) and less professional contacts in this setting?
- How does the program handle dilemmas between role clarity and accomplishing multiple tasks (e.g., especially in residential work and counseling or case management, there are significant possibilities for more personal and less professional relationships)?
- How does the program communicate reasonable expectations regarding the completion of particular tasks or the receipt of services? Is the information realistic about the program's lack of control in certain circumstances (e.g., in housing renovation or time to receive entitlements)? Is unnecessary consumer disappointment avoided?
- What is involved in the informed consent process? Is both the information provided and the consent obtained taken seriously? That is, are the goals, risks, and benefits clearly outlined and does the consumer have a genuine choice to withhold consent or give partial consent?

Domain 1C. Choice—Maximizing Consumer Choice and Control.

♦ ***Key Questions: "To what extent do the program's activities and settings maximize consumer experiences of choice and control? How can services be modified to ensure that consumer experiences of choice and control are maximized?"***

Sample Specific Questions:

- How much choice does each consumer have over what services he or she receives? Over when, where, and by whom the service is provided (e.g., time of day or week, office vs. home vs. other locale, gender of provider)?
- Does the consumer choose how contact is made (e.g., by phone, mail, to home or other address)?
- Does the program build in small choices that make a difference to consumer-survivors (e.g., When would you like me to call? Is this the best number for you? Is there some other way you would like me to reach you or would you prefer to get in touch with me?)

- How much control does the consumer have over starting and stopping services (both overall service involvement and specific service times and dates)?
- Is each consumer informed about the choices and options available?
- To what extent are the individual consumer's priorities given weight in terms of services received and goals established?
- How many services are contingent on participating in other services? Do consumers get the message that they have to "prove" themselves in order to "earn" other services?
- Do consumers get a clear and appropriate message about their rights and responsibilities? Does the program communicate that its services are a privilege over which the consumer has little control?
- Are there negative consequences for exercising particular choices? Are these necessary or arbitrary consequences?
- Does the consumer have choices about who attends various meetings? Are support persons permitted to join planning and other appropriate meetings?

Domain 1D. <u>Collaboration</u>—Maximizing Collaboration and Sharing Power

♦ ***Key Questions: "To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers? How can services be modified to ensure that collaboration and power-sharing are maximized?"***

Sample Specific Questions:

- Do consumers have a significant role in planning and evaluating the agency's services? How is this "built in" to the agency's activities? Is there a Consumer Advisory Board? Are there members who identify themselves as trauma survivors? Do these individuals understand part of their role to serve as consumer advocates? As trauma educators?
- Do providers communicate respect for the consumer's life experiences and history, allowing the consumer to place them in context (recognizing consumer strengths and skills)?
- In service planning, goal setting, and the development of priorities, are consumer preferences given substantial weight?
- Are consumers involved as frequently as feasible in service planning meetings? Are their priorities elicited and then validated in formulating the plan?
- Does the program cultivate a model of doing "with" rather than "to" or "for" consumers?
- Does the program and its providers communicate a conviction that the consumer is the ultimate expert on her or his own experience?
- Do providers identify tasks on which both they and consumers can work simultaneously (e.g., information-gathering)?

Domain 1E. Empowerment—Prioritizing Empowerment and Skill-Building

♦ ***Key Questions: "To what extent do the program's activities and settings prioritize consumer empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximized?"***

Sample Specific Questions:

- Do consumer-survivor advocates have significant advisory voice in the planning and evaluation of services?
- In routine service provision, how are each consumer's strengths and skills recognized?
- Does the program communicate a sense of realistic optimism about the capacity of consumers to reach their goals?
- Does the program emphasize consumer growth more than maintenance or stability?
- Does the program foster the involvement of consumers in key roles wherever possible (e.g., in planning, implementation, or evaluation of services)?
- For each contact, how can the consumer feel validated and affirmed?
- How can each contact or service be focused on skill-development or enhancement?
- Does each contact aim at two endpoints whenever possible: (1) accomplishing the given task and (2) skill-building on the part of the consumer?

Domain 1F. Safety for Staff—Ensuring Physical and Emotional Safety

♦ ***Key Questions: "To what extent do the program's activities and settings ensure the physical and emotional safety of staff members? How can services be modified to ensure this safety more effectively and consistently?"***

Sample Specific Questions:

- Do staff members feel physically safe?
- Do staff members feel emotionally safe?
- Is the physical environment safe--with accessible exits, readily contacted assistance if it is needed, enough space for people to be comfortable, and adequate privacy?
- Do staff members feel comfortable bringing their clinical concerns, vulnerabilities, and emotional responses to client care to team meetings, supervision sessions or a supervisor?
- Does the program attend to the emotional safety needs of support staff as well as those of clinicians?

Domain 1G. Trustworthiness for Staff—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

♦ ***Key Questions: "To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the***

program? How can services and work tasks be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximize honesty and transparency?"

Sample Specific Questions:

- Do program directors and clinical supervisors have an understanding of the work of direct care staff? Is there an understanding of the emotional impact (burnout, vicarious trauma, compassion fatigue) of direct care? How is this understanding communicated?
- Is self-care encouraged and supported with policy and practice?
- Do all staff members receive clinical supervision that attends to both consumer and clinician concerns in the context of the clinical relationship? Is this supervision clearly separated from administrative supervision that focuses on such issues as paperwork and billing?
- Do program directors and supervisors make their expectations of staff clear? Are these consistent and fair for all staff positions, including support staff?
- Do program directors and supervisors make the program's mission, goals, and objectives clear?
- Do program directors and supervisors make specific plans for program implementation and changes clear? Is there consistent follow through on announced plans? Or, in the event of changed plans, are these announced and reasons for changes explained?
- Can supervisors and administrators be trusted to listen respectfully to supervisees' concerns—even if they don't agree with some of the possible implications?

Domain 1H. Choice for Staff—Maximizing Staff Choice and Control.

♦ Key Questions: "To what extent do the program's activities and settings maximize staff experiences of choice and control? How can services and work tasks be modified to ensure that staff experiences of choice and control are maximized, especially in the way that staff members' work goals are met?"

Sample Specific Questions:

- Is there a balance of autonomy and clear guidelines in performing job duties? Is there attention paid to ways in which staff members can make choices in how they meet job requirements?
- When possible, are staff members given the opportunity to have meaningful input into factors affecting their work: size and diversity of caseload, hours and flex-time, when to take vacation or other leave, kinds of training that are offered, approaches to clinical care, location and décor of office space?

Domain 1I. Collaboration for Staff—Maximizing Collaboration and Sharing Power

♦ Key Questions: "To what extent do the program's activities and settings maximize collaboration and sharing of power among staff, supervisors, and administrators (as

well as consumers)? How can services be modified to ensure that collaboration and power-sharing are maximized?"

Sample Specific Questions:

- Does the agency have a thoughtful and planned response to implementing change that encourages collaboration among staff at all levels, including support staff?
- Are staff members encouraged to provide suggestions, feedback, and ideas to their team and the larger agency? Is there a formal and structured way that program administrators solicit staff members' input?
- Do program directors and supervisors communicate that staff members' opinions are valued even if they are not always implemented?

Domain 1J. <u>Empowerment for Staff</u>—Prioritizing Empowerment and Skill-Building

♦ ***Key Questions: "To what extent do the program's activities and settings prioritize staff empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of staff skills are maximized? How can the program ensure that staff members have the resources necessary to do their jobs well?"***

Sample Specific Questions:

- Are each staff member's strengths and skills utilized to provide the best quality care to consumers/clients and a high degree of job satisfaction to that staff member?
- Are staff members offered development, training, or other support opportunities to assist with work-related challenges and difficulties? To build on staff skills and abilities? To further their career goals?
- Do all staff members receive annual training in areas related to trauma, including the impact of workplace stressors?
- Do program directors and supervisors adopt a positive, affirming attitude in encouraging staff, both clinicians and support staff, to fulfill work tasks?
- Is there appropriate attention to staff accountability and shared responsibility or is there a "blame the person with the least power" approach? Is supervisory feedback constructive, even when critical?

<u>Domain 2. Formal Services Policies</u>

Key Questions: "To what extent do the formal policies of the program reflect an understanding of trauma survivors' needs, strengths, and challenges? Of staff needs? Are these policies monitored and implemented consistently?"

<u>Some Possible Indicators</u>**:**

♦Policies regarding confidentiality and access to information are clear; provide adequate protection for the privacy of both consumers and staff members; and are communicated to the consumer and staff in an appropriate way.

♦The program avoids involuntary or potentially coercive aspects of treatment—involuntary hospitalization or medication, representative payeeship, outpatient commitment—whenever possible.

♦The program has developed a de-escalation or "code blue" policy that minimizes the possibility of retraumatization.

♦The program has developed ways to respect consumer preferences in responding to crises—via "advance directives" or formal statements of consumer choice.

♦The program has a clearly written, easily accessible statement of consumers' and staff members' rights and responsibilities as well as a grievance policy.

♦The program's policies address issues related to staff safety. For example:

- Policies address if and when a staff member may be alone in the building or on duty.
- Policies govern specific ways for staff to offer home or community based services.
- Incident reviews follow verbal or physical confrontations and lead to effective plans to reduce staff vulnerability.

Domain 3. Trauma Screening, Assessment, Service Planning and Trauma-Specific Services

Key Question: "To what extent does the program have a consistent way to identify individuals who have been exposed to trauma, to conduct appropriate follow-up assessments, to include trauma-related information in planning services with the consumer, and to provide access to effective and affordable trauma-specific services?"

Some Possible Indicators**:**

♦Staff members have reviewed existing instruments to see the range of possible screening tools.

♦At least minimal questions addressing physical and sexual abuse are included in trauma screening:

♦Screening avoids overcomplication and unnecessary detail so as to minimize stress for consumers.

♦The program recognizes that the process of trauma screening is usually much more important than the content of the questions. The following have been considered:

- What will it mean to ask these questions?

- How can they be addressed most appropriately—for the likely consumers, for the service context, time available, prior relationship, possible future relationship, at various points in the intake/assessment process?

♦The need for standardization of screening across sites is balanced with the unique needs of each program or setting.

♦The screening process avoids unnecessary repetition. While there is no need to ask the same questions at multiple points in the intake or assessment process, there is often a good rationale for returning to the questions after some appropriate time interval.

♦Screening is followed as appropriate (given the nature and goals of the program, the length of time consumers are involved, and the specific relationships established with staff members) by a more extensive assessment of trauma history (type, duration, and timing of trauma) and of trauma-related sequelae (addressing resilience-related strengths and coping skills as well as vulnerabilities and problems).

♦In service planning, clinicians and consumers discuss ways in which trauma may be taken into account in clinicians' work with the consumer to achieve the consumer's goals (e.g., the place of trauma and trauma-related strengths and problems in giving shape to the recovery plan, its priorities, and the services and other supports that may be useful).

♦The program either offers or makes referrals to accessible, affordable, and effective trauma-specific services. Group and individual approaches to trauma recovery and healing are both available.

Part B: Systems-level/Administrative Changes

Domain 4. Administrative Support for Program-Wide Trauma-Informed Services

Key Question: " To what extent do program or agency administrators support the integration of knowledge about violence and abuse into all program practices?"

Some Possible Indicators**:**

♦The existence of a policy statement or the adoption of general policy statement from other organizations that refers to the importance of trauma and the need to account for consumer experiences of trauma in service delivery.

♦The existence of a "trauma initiative" (e.g., workgroup, trauma specialist).

- Designation of a competent person with administrative skills and organizational credibility for this task.
- Chief administrator meets periodically with trauma workgoup or specialist.
- Administrator supports the recommendations of the trauma workgroup or specialist and follows through on these plans.

♦Administrators work closely with a Consumer Advisory group that includes significant trauma survivor membership. Consumer-survivor members of this group identify themselves as trauma survivors and understand a part of their role as consumer advocacy. They.play an active role in all aspects of service planning, implementation, and evaluation.

♦Administrators are willing to attend trauma training themselves (vs. sending designees in their places); they allocate some of their own time to trauma-focused work (e.g., meeting with trauma initiative representatives, keeping abreast of trauma initiatives in similar program areas).

♦Administrators make basic resources available in support of trauma-informed service modifications (e.g., time, space, training money).

♦Administrators support the availability and accessibility of trauma-specific services where appropriate; they are willing to be creative about finding alternative reimbursement strategies for trauma services.

♦Administrators find necessary sources of funding for trauma training and education (this sometimes requires going outside the usual funding mechanisms in a creative way).

♦Administrators are willing to release line staff from their usual duties so that they may attend trainings and deliver trauma services. Funding is sought in support of these activities.

♦Administrators participate actively in identifying objectives for systems change.

♦Administrators monitor the program's progress by identifying and tracking core objectives of the trauma-informed change process.

♦Administrators may arrange pilot projects for trauma-informed parts of the system.

Domain 5. Staff Trauma Training and Education

Key Question: "To what extent have all staff members received appropriate training in trauma and its implications for their work?"

Some Possible Indicators**:**

♦General education (including basic information about trauma and its impact) has been offered for all employees in the program with a primary goal of sensitization to trauma-related dynamics and the avoidance of retraumatization.

♦Staff members have received education in a trauma-informed understanding of unusual or difficult behaviors. (One of the emphases in such training is on respect for people's coping attempts and avoiding a rush to negative judgments.)

♦Staff members have received basic education in the maintenance of personal and professional boundaries (e.g., confidentiality, dual relationships, sexual harassment).

♦Clinical staff members have received trauma education involving specific modifications for trauma survivors in their content area: clinical, residential, case management, substance use, for example.

♦Clinical staff members have received training in trauma-specific techniques for trauma clinicians.

♦Staff members offering trauma-specific services are provided adequate support via supervision and/or consultation (including the topics of vicarious traumatization and clinician self-care).

Domain 6. Human Resources Practices: "To what extent are trauma-related concerns part of the hiring and performance review process?"

Key Question: "To what extent are trauma-related concerns part of the hiring and performance review process?"

Some Possible Indicators**:**

♦The program seeks to hire (or identify among current staff) trauma "champions," individuals who are knowledgeable about trauma and its effects; who prioritize trauma sensitivity in service provision; who communicate the importance of trauma to others in their work groups; and who support trauma-informed changes in service delivery.

♦Prospective staff interviews include trauma content (What do applicants know about trauma? about domestic violence? about the impact of childhood sexual abuse? Do they understand the long-term consequences of abuse? What are applicants' initial responses to questions about abuse and violence?)

♦Incentives, bonuses, and promotions for line staff and supervisors take into account the staff member's role in trauma-related activities (specialized training, program development, etc.).

Addendum A: Possible Items for Consumer Satisfaction Surveys

(Items are worded to be consistent with a Likert response scale from "strongly disagree" to "strongly agree;" specific items and wording should be tailored to the program's goals and services)

Safety
- When I come to [program], I feel physically safe.
- When I come to [program], I feel emotionally safe.

Trustworthiness
- I trust the people who work here at [program].
- [Program] provides me good information about what to expect from its staff and services.
- I trust that people here at [program] will do what they say they are going to do, when they say they are going to do it.
- The people who work here at [program] act in a respectful and professional way toward me.

Choice

- [Program] offers me a lot of choices about the services I receive.
- I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered.
- People here at [program] really listen to what I have to say about things.

Collaboration
- At [program], the staff is willing to work with me (rather than doing things for me or to me).
- When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want to accomplish.
- Consumers play a big role in deciding how things are done here at [program].

Empowerment
- [Program] recognizes that I have strengths and skills as well as challenges and difficulties.
- The staff here at [program] are very good at letting me know that they value me as a person.
- The staff here at [program] help me learn new skills that are helpful in reaching my goals.
- I feel stronger as a person because I have been coming to [program].

Trauma Screening Process
- The staff explained to me why they asked about difficult experiences in my life (like violence or abuse).
- The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had.
- I feel safe talking with staff here about my experiences with violence or abuse.

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PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY

Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Needs and their Families

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently, or statement applies to me to a great degree
B = Things I do occasionally, or statement applies to me to a moderate degree
C = Things I do rarely or never, or statement applies to me to minimal degree or not at all

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

_____ 1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I insure that toys and other play accessories in reception areas and those, which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.

COMMUNICATION STYLES

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children who have limited English Proficiency.

_____ 10. I use bilingual staff or trained/certified interpreters during assessments, treatment sessions, meetings, and for or other events for families who would require this level of assistance.

11. When interacting with parents who have limited English proficiency I always keep in mind that:

_____ * limitations in English proficiency are in no way a reflection of their level of intellectual functioning.

_____ * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ * they may or may not be literate in their language of origin or English.

_____ 12. When possible, I insure that all notices and communiqués to parents are written in their language of origin.

_____ 13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

_____14. I understand the principles and practices of linguistic competency and:

_____ * apply them within my program or agency.

_____ * advocate for them within my program or agency.

_____ 15. I understand the implications of health literacy within the context of my roles and responsibilities.

_____ 16. I use alternative formats and varied approaches to communicate and share information with children and/or their family members who experience disability.

VALUES AND ATTITUDES

_____ 17. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 18. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 19. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.

_____ 20. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.

_____ 21. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____ 22. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 23. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

_____ 24. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).

_____ 25. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____ 26. I recognize that the meaning or value of medical treatment, health and mental health care, and special education may vary greatly among cultures.

_____ 27. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.

_____ 28. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

_____ 29. I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability and death.

_____ 30. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.

VALUES AND ATTITUDES (CONT'D)

_____ 31. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 32. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

_____ 33. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 34. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 35. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 36. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

How to use this checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children with disabilities or special health care needs and their families.

APPENDIX F

CLINICAL SUPERVISION IMPLEMENTATION GUIDE

A practical implementation guide for community-based behavioral health specialty organizations

Practical Resources and Tools

October 5, 2018

Introduction

This **Clinical Supervision Implementation Guide** is offered as a practical guide for clinical supervisors to support their local clinical practice. It includes topics addressing clinical supervision implementation within community-based behavioral health specialty organizations. Only the first section reflects some policies from the Behavioral Health Services Division, Human Services Department. Otherwise, the balance of the materials are gleaned from local practice and/or national research. All attempts were made to properly credit sources. In 2019, we anticipate state agency rule changes that will further support growing the behavioral health workforce and align with best practices. This is a 'living document"; we encourage readers to make ongoing contributions to its content

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Table of Content

I. Clinical Supervision and Clinical Practice Guidelines, Behavioral Health Services Division, Human Services Department

A. Overview:

Clinical supervision instructs, models, and encourages self-reflection of the supervisee's acquisition of clinical and administrative skills through observation, evaluation, feedback, and mutual problem-solving. However, it should be understood that there might be opportunities in which the clinical supervisor chooses to give professional direction based on experience, expertise, and/or for ethical or safety concerns. Clinical supervision is delivered within the supervisor's professional practice license and ethical standards.

Clinical supervision is provided to all treatment/clinical staff who are either employed or under contract by a provider organization such as group practices or behavioral health specialty organization or an individual provider.

- Clinical supervisors need to meet the standards for clinical supervision as defined by their professional practice board.
- Clinical supervisor responsibilities: provide support, consultation, and oversight of clients' treatment to include: assessment of needs; diagnoses/differential diagnoses (MH, SA, and COD); clinical reasoning and case formulation which addresses documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions. All of the above should be:
    - Continuously reviewed and adjusted according to an individual's status, success and challenges.
    - Teaching the importance of retaining continuity throughout all documentation.
    - Ensuring plans, interventions, goals, and supports are appropriate to diagnosis.
- Clinical Supervision assures that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the individual's continued recovery and success.
- Clinical Supervision assures that an appropriate safety and crisis management plans are in place at the onset of service delivery.
- Clinical Supervision addresses ethics and ethical dilemmas as aligned with the appropriate professional practice board.

Clinical Supervisors will document date, duration, and the content of supervision session for their supervisee(s), which may include a professional development plan. All

documents pertaining to clinical supervision will be readily available to the supervisee.

B. Staff Qualifications:

A clinical supervisor has been approved by their respective professional licensing board as having met board requirements for providing clinical supervision. Please see http://www.rld.state.nm.us/boards/default.aspx for current requirements.

C. Guidelines for Clinical Practice and Clinical Supervision

1. Introduction:

The term *practice* refers to the collective set of actions used to plan and deliver interventions and supports. Practice takes place in collaboration with the person(s) served and the social and service- related networks and supports available to help meet the person's individualized and/or family needs and is guided by self-determination and individual choice. The purpose of practice is to help a person or family to achieve an adequate level of:

- **Well-being** (e.g., safety, stability, permanency for dependent children, physical and emotional health),
- **Daily functioning** (e.g., basic tasks involved in daily living, as appropriate to a person's life stage and ability),
- **Basic supports for daily living** (e.g., housing, food, income, health care, child care), and
- **Fulfillment of key life roles** (e.g., a child being a successful student or an adult being a successful parent or employee).

2. Basic Expectations of High Quality Practice:

There are five basic functions of quality practice that must be performed for each person served to achieve the greatest benefits and outcomes. These functions listed below are foundational to quality practice and underlie all successful intervention strategies. Because these functions are essential to achieving positive results with clients served, the Behavioral Health Services-Division expects that each person served will, at a minimum, be served in a manner that consistently provides and demonstrates these core practice functions. Providing services to all clients in accordance with these practices is a top priority, and the Behavioral Health Services Division will support organizations to consistently measure their occurrence with clients served using Integrated Quality Service Reviews (iQSR), Clinical Supervision and Quality Improvement strategies based on their organization's comprehensive and ongoing self-assessments. Agencies are encouraged to develop strong internal clinical practice development activities including integration of the iQSR or

other data-driven fidelity models.

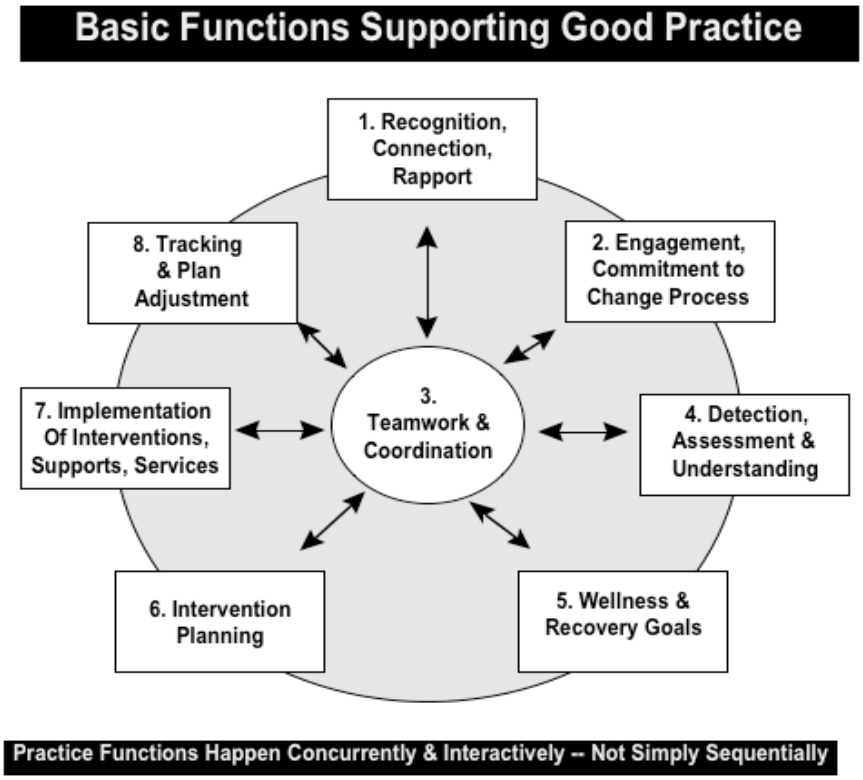
3. Basic Functions of High Quality Practice:

This practice framework sets forth the actions/functions used by frontline practitioners to partner with a person receiving services to bring about positive life changes that assist the person by maintaining successes and managing challenges as they occur. Typical activities in practice include engaging the client and other key stakeholders in a connected, unifying effort through teamwork and fully understanding the person, their needs and environment. It also includes collaboratively defining results to be achieved, selecting and using intervention strategies and supports, resourcing and delivering planned interventions and supports, and tracking and adjusting intervention strategies until desired outcomes are achieved.
The basic functions of quality practice are:

- Engaging Service Partners
- Assessing and Understanding the Situation
- Planning Positive Life-Change Interventions
- Implementing Services
- Getting and Using Results

4. The Practice Wheel: A Practice Model Defines the Principles and Organizing Functions Used by Practitioners

The practice framework also encompasses the core values and expectations for providing services. The framework functions to organize casework and service delivery, to guide the training and supervision of staff, and clarifies quality measures and accountability. Basic practice functions are illustrated in the “practice wheel” diagram below. The practice wheel can be utilized to guide supervision by providing a framework and expectations for working with persons receiving services. For example, supervision and training could progress along the practice wheel with each function as a topic of focus to strengthen and operationalize expectations.



5. Clinical Supervision as a Foundation For Strong Clinical Practice:

Clinical Supervision is the foundation for assuring consistent, high quality practice. It provides a mechanism for clinical practice improvement at both an individual staff level as well as at the organizational level.

6. Individual Practitioner Level Supervision:

The Clinical Supervision for individual frontline practitioners should consistently:

- Provide support, consultation, and oversight of clients' treatment to include assessment of needs; diagnoses/differential diagnoses (MH, SA, and COD); clinical reasoning and case formulation, to include documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions.
  - All of which should be continuously reviewed and adjusted according to an individual's status, success and challenges. Teach the importance of retaining continuity throughout all documentation.
  - Ensure plans, interventions, goals, and supports are appropriate to diagnosis; and, aligned with the supervisee's theoretical orientations

- Use parallel process where the supervisee's development is being addressed alongside the emerging clinical issues.

- Address the supervisee's steps to insure an individual's active involvement at all levels and that the individual voice and choice are clearly represented and documented.
- Assure that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the individual's continued recovery and success.
- Assure that an appropriate safety and crisis management plans are in place at the onset of service delivery.
- Address ethics and ethical dilemmas as aligned with the appropriate professional practice board.

7. Group Level Supervision:

In addition to reinforcing multi-disciplinary teaming, group supervision can serve as a good teaching/training venue in which provider trends are highlighted (e.g. engagement, population profiles, and the presenting severity/types of disorders, theoretical orientation and case conceptualization.) The Clinical Supervisor's experiences in group supervision can also inform and strengthen the work of the entire team through the use of a recognized Clinical Practice Improvement model.

8. Organizational Level Benefits of Clinical Supervision:

- Assures high quality treatment for individuals.
- Creates clearly defined treatment goals which are measurable and time limited
- Assures the treatment plan is a living, working document with the individual.
- Ensures proper documentation of care and can help with program integrity issues
- Ensures staff are trained and properly implementing Evidenced-based Practices.
- Ensures fidelity to evidenced based practice models (e.g. Multisystem Therapy, Integrated Dual Diagnosis Treatment, Substance Abuse Matrix model)
- Improves staff development and employee retention
- Provides a risk management tool (e.g. Reduction of critical incidence)

9. Organizational Expectations:

Agencies are expected to have policies and procedures that assure that:

- Clinical Supervision is conducted in a manner that ensures adequate attention to each supervisee and quality oversight for the cases;
- Clinical Supervision occurs frequently and follows a structured process that includes individual & group, clinical oversight, and regular access to supervisors;
- Both individual and group clinical supervision occurs multiple times during any month with documentation to evidence that clinical supervision has occurred accordingly.
- All individual practitioner's, group practices' and facilities' Quality Improvement Program should have a Clinical Practice Improvement program that:
  - Utilizes the findings from its Clinical Supervision to the improve the provider performance;
  - Addresses care planning consistent with: wraparound planning approaches; system of care principles; and, a recovery philosophy.
  - Includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring.
  - Has a review protocol should examine strengths and improvements in the following areas:
    - Engagement
    - Teamwork
    - Assessment & understanding
    - Outcomes & goals
    - Intervention planning
    - Resources
    - Adequacy of interventions
    - Tracking and adjustment

10. Guiding Values and Principles of Practice

The Behavioral Health Services Division, Human Services Department and the New Mexico Behavioral Health Collaborative hold the following values and principles for practice in the provision of services to all individuals, youth and families served within the public behavioral health system:

- Individual/family- driven, individualized and needs-based
- Developmentally appropriate
- Inclusive of family or natural supports
- Offers an array of services & supports
- High quality
- Community-based.

- Culturally and linguistically aware and accepting
- Use of early identification and intervention
- Integrative approach
- Trauma responsive
- Strength-based
- Outcome based
- Least restrictive
- Recognize perseverance and resiliency/ trauma informed

11. State Monitoring of Clinical Practice and Clinical Supervision

Medicaid funded and state funded agencies who wish to use non-independently licensed providers will need to submit the Supervisory Certification Attestation Form. Contact (BILS4NILS.BHSD@state.nm.us). A staff roster must accompany the attestation with each independent and non-independent provider listed. For the supervisors, please include a letter from the licensing Board designating them as supervisors (LCSW or LISW) or their most recent CEUs in supervision that accompanied their last license renewal (LPCC.) Once approved, the provider will need to submit their Supervisory Certification notice to the MCO's and Medicaid so that they can render services.

Each time the provider brings on a new non-independently licensed provider, or changes supervisors, they will need to submit an updated roster (with all the columns filled out). For Supervisors, please include a letter from the licensing Board designating them as supervisors (LCSW or LISW) or their most recent CEU's in supervision that accompanied their license renewal (LPCC).

12. Clinical Supervision Documentation:

The organization's documentation will include:

- Policies that describe the provider's clinical supervision of all treatment staff including their Human Resources requirements for the clinical supervisor (credentials, job description, skill sets, training requirements and schedules).
- Procedures will include:
  - A template that documents when and how clinical supervision is provided to individuals and multidisciplinary teams in individual and group settings;
  - Annual training plan for all staff that provide treatment services.
  - Backup contingency plans for periods of clinical supervisor staff turnover.

13. Clinical Practice Improvement:

The organization's Quality Improvement Program must have a Clinical Practice Improvement component that:

- Addresses care planning consistent with holistic and comprehensive care planning, system of care principles and, a recovery and resiliency philosophy;
- Examines the provider's strength and weaknesses in the clinical care functions of: engagement, teamwork, assessment & understanding, outcomes & goals, intervention planning, resources, adequacy of intervention, and tracking & adjustment;
- Includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring;
- Evaluates the outcomes of its clinical interventions and develops improved strategies.

14. Technical Assistance from the State:

- State staff will monitor agencies for compliance with this clinical supervision requirement should the need arise.
- Dedicate resources and personnel (i.e., state employees or contracted clinicians) to provide technical assistance in identifying acceptable and appropriate policies and procedure through the Supervisory Certification process.
- Explore use of telehealth video conferencing as a tool in clinical supervision.
- Provide Clinical Reasoning and Case Formulation training and consultation to Clinical Supervisors.
- Provide training and supports for supervising specific to those working in integrated settings and teams.

II. The Clinical Supervision Experience

A. Introduction:

Supervision is part of one's professional practice, education and training in which the supervisor and supervisee collaborate to develop the supervisee's skills in evidence-based and effective promising practices as well as to protect the welfare of clients served. The provider organization of both the supervisor and supervisee will benefit from having formal agreements (or contracts), expectations, and policies related to the provision of supervision. Modifications may be necessary in the event that an organization is not able to provide a supervisor from within (internal to the provider). In these situations, the organization will benefit from having specific policies and contracts with external supervisors to ensure that all parties are familiar with the expectations, legal responsibilities, and roles. Furthermore, organizations as well as all supervisors and supervisees will benefit from a comprehensive understanding of the provider policies, state licensing board regulations, and documentation that may differ depending upon disciplines. For example, many boards stipulate specific requirements to become an eligible supervisor, documentation, and required hours. Please consult all these resources prior to initiation of the clinical supervision experience. (See Appendix F for further information on regulations.)

B. Best Practice Guidelines

Discipline specific best practice guidelines related to supervision promote high standards to guide clinicians. Please consult each of these as relevant:

- American Psychological Association Guidelines for Clinical Supervision in Health Service Psychology
- Association for Counselor Education and Supervision of the American Counseling Association Best Practices in Clinical Supervision
- National Association of Social Workers Best Practice Standards in Social Work Supervision

C. The Clinical Supervision Relationship

Both supervisor and supervisee will benefit from understanding their roles and the professional responsibilities that each person has in order to uphold their responsibilities and understand the expectations that come along with such an important relationship. The Clinical Supervision Relationship (link) addresses critical responsibilities of both parties.

D. The Rights and Responsibilities of Supervisor and Supervisee

In order to promote a healthy and collaborative supervisory relationship, both the supervisor and supervisee benefit from having clear rights and responsibilities. The Rights

and Responsibilities addresses these in a coherent framework compiled from multiple sources.

E. The Supervision Plan

An effective clinical supervision plan is a well-developed agreement or contract resulting in appropriate care for patients, professional growth for the supervisee, and management of liabilities and roles. These agreements contain an outline of goals of supervision, the structure of supervision and duties/responsibilities of both supervisor and supervisee. Agreements for group vs. individual supervision will be different. Acquiring clinical supervision outside of the provider organization intensifies the need for a well-developed supervision plan to make clear the management of liabilities and responsibilities. Development of an effective supervision plan with collaboration of supervisor and provider will insure a successful outcome for all involved. Examples are below for your reference and modification:

- Counselor Supervision Contract
- Substance abuse counselor supervision agreement
- Psychology supervision contract
- Social work supervision contract

F. Documenting supervision: Clinical Supervision Record

The documentation of supervision meetings is essential to guide both the supervisor and supervisee. It serves as a record to monitor and provide essential feedback and evaluation for the supervisee and assure continuity of follow-up from session to session. Some disciplines suggest that *both* supervisor and supervisee maintain documentation of their progress tacking supervisory sessions.

The clinical supervision record template inserted below contains helpful elements that may be pertinent to agencies implementing the Treat First (TF) in New Mexico. Areas in which to record specific client feedback from TF check-in and TF overall evaluation of the clinician by the client is incorporated along with additional content items and quality indicators. The form may be revised according to each organization's requirements as well as individual supervision needs. Group supervision formats may indicate further modifications to the form.

Additional examples of supervision records include:

- Documenting Supervision
- **Supervisor Session: Bridging Form**

Following documentation of the supervisory session, the Supervisory Session Bridging Form may be utilized to facilitate the supervisory alliance between supervisor and supervisee and provide them with essential feedback to enhance supervision.

Clinical Supervision Record - Treat First

Date: **Starting Time:** **Ending Time:**

Supervisee/Employee: **Supervisor:**

Circle Method(s): Ind/Group; In-person or via teleconference webcam; live, audio recording, Other:

Clinical Issues discussed (do not include patient info): **% of supervision: _____**

Ethics & Legal Issues
Informed Consent / Confidentiality / Releases of Information
Competency
Dual Relationships / Boundaries
Case Conceptualization
Risk Assessment / Crisis Intervention
Safety Planning Diagnosis / Assessment Substance Use Treatment Trauma Informed Care Treatment Planning
Client Progress & use of measures/ Assessments of progress
Team Meetings / Treatment Team collaboration!
Evidence Based Practice / Promising Practices
Practice/ Intervention skills
Emergent client situations
Multicultural / Diversity Issues; Language
Community Supports/Information & Referrals
School/Employment issues for clients
Documentation / Progress Notes
Individual/Family/Group issues
Termination / Discharge issues
Transference / Countertransference
Supervisee emotional reactivity
Supervisee self-exploration / Self-awareness
Supervisee self-care
Duties /expectations / responsibilities
Professionalism
Communication skills of supervisee
Time management of supervisee
Attitude/Judgment of supervisee
Problem solving of supervisee
Flexibility of supervisee
Supervision Goals & Objectives
Supervisee Training Plan
Policy / Procedures
Licensure requirements for supervision

Data / Productivity issues discussed **% of supervision: _**

Patient Satisfaction Surveys
Treat First (TF) Session Check-In
Treat First Overall Evaluation of Work Together
Caseload
New Assessments (same-day intakes / TF)
Monthly Productivity Encounters: Individual / Group:
No-shows / Cancellations
Treatment Plans current (90 days)
Notes completed and locked within 48 hours
Peer Review Chart Audits

Training discussed **% of supervision: _____**

Online/provider req'd
CEUs
CPR / CPI

Administrative discussed **% of supervision: _____**

Community involvement
Licensure renewal / requirements

Resources / literature / material discussed **% of supervision: ____**

Supervisee strengths/challenges **% of supervision: _____**

Tasks to be completed:

Comments/Observations:

Signatures

Supervisor:

Supervisee

III. Clinical Supervision Preparation Tools

The Case Discussion Guide for Reflective Practice (**See Appendix C**) serves to structure reflective case discussion in supervision and supports both supervisor and supervisee. The Case Discussion Guide for Reflective Practice is especially useful for new supervisors to build a flow of reflective conversation without getting lost in conversation with a supervisee. This guide is also useful in preparing supervisees for sessions by clarifying what occurs during clinical supervisions sessions and setting a standard of expectation for preparation and participation in sessions.

The following are organizers for practice and casework based on a traditional bio-psycho-social grid. These organizers can be used to assist supervisees in preparing for supervision sessions, with a secondary benefit of building strong habits in clinical reasoning and case formulation. While use of these organizers is strongly supported, it is not suggested that all organizers be used every-time for every supervision session. These organizers are tools for supervisors and supervisees to make efficient use of the clinical supervision time and to build reasoning skills in practitioners. (**See Appendix D** for fillable forms that can be downloaded**.)**

On the next page, the first of the organizers, the **Bio-Psycho-Social** (BPS) Framework, is presented. It is a tool used for organizing information about a person's life situation to help reveal importation fact patterns necessary developing a clinical understanding. A basic bio-psycho-social grid gives a foundation for gathering and organizing information about a person in services or seeking services, providing a holistic view of the person.

The BPS framework provided below synthesizes data into easily understood components, called the "5-Ps". The "5-Ps" identify Predisposing, Precipitating, Perpetuating, Protective, and Predictive Factors that each and every practitioner should know about a person's life situation as a basis for developing a clinical case formulation, documentation, and work with a person. These "5-Ps" are applied across a person's physical, psychological, and social history and present situation to develop clinical insights that will be useful in planning interventions, supports, and services.

Bio-Psycho-Social Assessment

Note: A bio-psycho-social assessment organizer is used for noting historic & current factors that explain a person's present situation and state of need. Used to answer clinical questions and plan a case formulation.

Key Factors	Biological Domain	Psychological Domain	Social Domain	
Explaining a Person's Life Circumstances/Problems	**Genetic, developmental, medical, toxicity, temperamental factors**	**Cognitive style, intra-psychic conflicts, defense mechanisms, self-image, meaning of symptoms**	**Social-relationships family/ peers/others**	**Social-environment cultural/ ethnicity, social risk factors**
Predisposing → (Vulnerabilities that tend to increase risks of the presenting problems)	Family psychiatric history, toxic exposures in utero, birth complications, developmental disorders, regulatory disturbances, traumatic brain injury (TBI)	Insecure attachment, problems with affect modulation, rigid or negative cognitive style, low self-image	Childhood exposure to maternal depression, domestic violence, late adoption, temperament mismatch, marital conflicts	Poverty, low socioeconomic status, teenage parenthood, poor access to health or mental health care
Precipitating → (Stressors and life events having a time relationship with the onset of symptoms and may serve as triggers)	Serious medical illness or injury, increasing use of alcohol or drugs	Conflicts around identity or separation-individuation arising at developmental transitions, such as puberty onset or graduation from high school	Loss or separation from close family member, family moved with loss of friendships, interpersonal trauma	Recent immigration, loss of home, loss of supportive services (e.g., respite services, school placement)
Perpetuating → (Ongoing life challenges and sources of needs)	Chronic illness, functional impairment caused by cognitive defects or learning disorder	Use of self-destructive coping mechanisms, help-rejecting personality style, traumatic re-enactments	Chronic marital/family discord, lack of empathy from parent, developmentally inappropriate expectations	Chronically dangerous or hostile neighborhood, trans-generational problems of immigration, lack of culturally competent services
Protective → (Functional strengths, skills, talents, interests, assets, work, supportive elements of the person's relationships)	Above-average intelligence, easy temperament, special talents or abilities, physical attractiveness, factors related to emotional intelligence	Ability to be reflective, ability to modulate affect, positive sense of self, adaptive coping mechanisms, other skills that build resiliency	Positive parent-child relationships, supportive community and extended family, family resources that support good health, development	Community cohesiveness, availability of supportive social network, well-functioning child/family team
Predictive → (Potential for change, areas most amenable to change as well as potential obstacles to positive change)	Sustained good health -or- worsening illness, persisting pattern of sobriety or addiction	Adaptive to unfolding life changes -or- resistant to current change efforts	Supportive friends and family members -or- destructive friends or toxic family relationships	Positive supports for life changes - or- ongoing unsolved social issues (undocumented or court orders)

Adapted from Barker, P. The child and adolescent psychiatry evaluation. Oxford, UK: Blackwell Scientific, Inc.; 1995.

The **Clinical Reasoning Worksheet** works to guide supervisees towards a clinical question for the supervision session, and to organize for oral presentation of a case for supervision. This organizer is particularly suited for new practitioners.

Clinical Reasoning Worksheet

10 Basic Clinical Reasoning Questions to Guide Case Formulation and Intervention Planning

Presented below are 10 clinical reasoning questions intended for use by practitioners, clinicians, and supervisors. These questions may be applied throughout a person's service process. Answers to these questions can help guide the clinical case formulation for a person receiving services as well as guide intervention planning, implementation, and completion or stepping down of interventions. When applied, these questions work well in group supervision situations.

1. **People Involved:** Who are the people involved in supporting and serving this person? How well are they engaged, involved, and committed to helping this person get better, do better, and stay better?

2. **Expectations:** What outcomes of intervention are people expecting to be achieved? The person? The family, life partner, and/or key supporters? The school or employer? The court? Other service providers?

3. **Causes & Contributors of Presenting Problems:** What bio-psycho-social factors, life circumstances, and underlying issues explain the person's presenting problem(s) and current unmet needs?

4. **Risk Factors:** Based on history and tendencies, what things could go wrong in this person's life? What must be done to avoid or prevent future harm, life disruption, pain, loss, or undue hardship?

5. **Functional Strengths & Assets:** What are the person's functional strengths, aspirations for change, and life assets that can be built up to solve the problem(s) that brought the person/family into services?

6. **Critical Unmet Needs:** What presently critical unmet needs would have to be fulfilled in order for this person to get better, do better, and stay better?

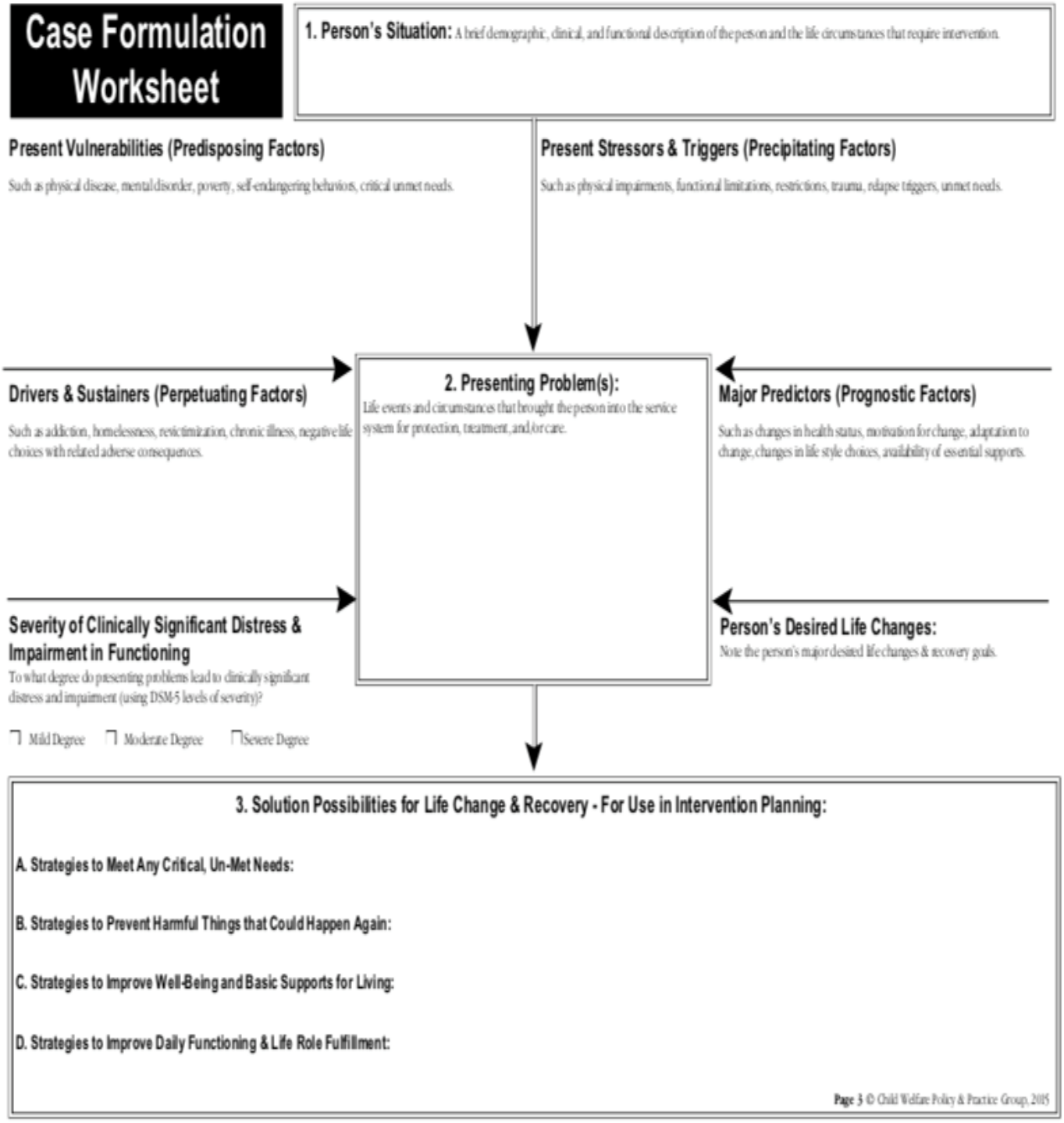
7. **Necessary Changes:** What things in the person's life would have to change in order for the person to achieve and maintain adequate well-being, have essential supports for living, function adequately in daily activities, and fulfill key life roles - as appropriate to life stage, capacities, and preferences?

8. **Outcome Indicators:** What life conditions, when met, will indicate that the person's problem(s) is/are solved and critical needs are met (e.g., achieved adequate well-being, has essential supports for living, functions adequately in daily activities, and fulfills key life roles)?

9. **Intervention Strategies:** What combination and sequence of intervention strategies are likely to bring about desired life changes and meet the youth's life-change goals or the adult's personal recovery goals?

10. **Results-Based Decisions:** How will people know and decide: (1) That interventions are being delivered and are working as planned? (2) When interventions should be changed or stopped? (3) When life-change outcomes have been substantially achieved? (4) When the person's needs are met, conditions for safe case closure are present, and intervention efforts can be safely and successfully reduced, transitioned, or concluded?

The **Case Formulation Worksheet** examines the pertinent factors influencing a person in services and build understanding of the whole picture of the person in context of a person's life experience.



The **Planning Worksheet** can be used with a practitioner is "stuck" in what actions should be taken next, when there is decreased or difficulty engaging a person in services, early in the delivery of care to build rapport and trust, or to organize and deconstruct actions in response to crisis or an emerging crisis.

Planning Worksheet

Person's Situation: A brief demographic, clinical, and functional description of the person and the person's life circumstances that require intervention.

GENERAL GUIDANCE: This worksheet is designed to help **conceptualize and organize intervention planning** for a person receiving services. It links together the **Life Change Outcomes** planned with and for the person, the **Intervention Strategies** that will be used to bring about **Outcomes/Life Changes**, and **Actions** planned to implement intervention strategies.

LOGIC OF APPROACH: The practitioner should first plan to meet any **Compelling Urgencies** requiring **Immediate Action** to prevent harm. After any such urgencies are addressed, focus next on any **Life Outcomes related to Achieving Well-Being** (e.g., safety, health, stability/permanency) and **Life Outcomes related to Supports for Living** (e.g., income, food, housing, health care). Once needs for well-being and supports for living are being met, the focus shifts to **Life Outcomes related to adequate Daily Functioning and fulfilling Key Life Roles**. This progression of meeting essential needs and strategic life changes should enable the person to achieve and maintain an adequate daily life situation and gain greater independence from the service system. When selecting from among near-term goals and strategies, the practitioner should give priority to any **Ready Opportunities** for getting **Early and Repeated Successes**. Likewise, **Priority** should be given any important life outcome that could be easily and readily achieved, leading to **Early Victories** or **Rapid Completions** in life change efforts.

ORDER AND PACE OF INTERVENTIONS: 1) Work from **Urgent to Strategic,** from **Practical to Clinical,** and from **Outcomes to Actions**; 2) **Define Outcomes** in operational terms and **then Select Intervention Strategies** for their attainment; 4) Select Strategies having **Ready Opportunities for Action**; 5) Select Strategic Options that can **Achieve a Rapid Outcome that Improves the Trajectory of the Person's Life**; 6) **Sustain Motivation** for life change by **Gaining Early and Repeated Successes**; and, 7) **Avoid a Scope and Pace of Action that would Overwhelm the Person's Life Situation** and could Cause Resistance and Loss of Motivation.

Outcomes by Priorities	Intervention Strategies (Methods Used to Make Changes)	Intervention Actions (Implementation Steps)
1. Compelling Urgency: Prevent harm		
2. Early Success: Turn an important corner		
3. Rapid Completion: Achieve a key victory		
4. Capacity Building: Build for long-term		

IV. Models of Clinical Supervision, Defined

A. Psychotherapy-based models of supervision often feel like a natural extension of the therapy itself. "Theoretical orientation informs the observation and selection of clinical data for discussion in supervision as well as the meanings and relevance of those data (Falender & Shafaanske, 2008, p. 9). Thus, there is an uninterrupted flow of terminology, focus, and technique from the counseling session to the supervision session, and back again.

1. Psychodynamic Approach to Supervision: As noted above, psychodynamic supervision draws on the clinical data inherent to that theoretical orientation (e.g., affective reactions, defense mechanisms, transference and countertransferece, etc.). Frawley-O'Dea and Sarnat (2001) classify psychodynamic supervision into three categories: patient-centered, supervisee-centered, and supervisory-matrixcentered. Patient-centered began with Freud and, as the name implies, focuses the supervision session on the patient's presentation and behaviors. The supervisor's role is didactic, with the goal of helping the supervisee understand and treat the patient's material. The supervisor is seen as the uninvolved expert who has the knowledge and skills to assist the supervisee, thus giving the supervisor considerable authority (Frawley-O'Dea & Sarnat, 2001).

    a. Supervisee-centered psychodynamic supervision came into popularity in the 1950s, focusing on the content and process of the supervisee's experience as a counselor (Frawley-O'Dea & Sarnat, 2001; Falender & Shafranske, 2008). Process focuses on the supervisee's resistances, anxieties, and learning problems (Falender & Shafranske). The supervisor's role in this approach is still that of the authoritative, uninvolved expert (Frawley-O'Dea & Sarnat), but because the attention is shifted to the psychology of the supervisee, supervision utilizing this approach is more experiential than didactic (Falender & Shafranske).

    b. The supervisory-matrix-centered approach opens up more material in supervision as it not only attends to material of the client and the supervisee, but also introduces examination of the relationship between supervisor and supervisee. The supervisor's role is no longer one of uninvolved expert. Supervision within this approach is relational and the supervisor's role is to "participate in, reflect upon, and process enactments, and to interpret relational themes that arise within either the therapeutic or supervisory dyads" (Frawley-O'Dea & Sarnat, 2001, p. 41). This includes an examination of parallel process, which is defined as "the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist" (Haynes, Corey, & Moulton, 2003).

2. Cognitive-Behavioral Supervision As with other psychotherapy-based approaches to supervision, an important task for the cognitive-behavioral supervisor is to teach the techniques of the theoretical orientation. Cognitive-behavioral supervision makes use of observable cognitions and behaviors—particularly of the supervisee's professional identity and his/her reaction to the client (Hayes, Corey, & Moulton, 2003). Cognitive-behavioral techniques used in supervision include setting an agenda for supervision sessions, bridging from previous sessions, assigning homework to the supervisee, and capsule summaries by the supervisor (Liese & Beck, 1997).

3.Person-Centered Supervision Carl Rogers developed person-centered therapy around the belief that the client has the capacity to effectively resolve life problems without interpretation and direction from the counselor (Haynes, Corey, & Moulton, 2003). In the same vein, person-centered supervision assumes that the supervisee has the resources to effectively develop as a counselor. The supervisor is not seen as an expert in this model, but rather serves as a "collaborator" with the supervisee. The supervisor's role is to provide an environment in which the supervisee can be open to his/her experience and fully engaged with the client (Lambers, 2000). In person-centered therapy, "the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship are the prime determinants of the outcomes of therapy" (Haynes, Corey, & Moulton, 2003, p. 118). Person-centered supervision adopts this tenet as well, relying heavily on the supervisor-supervisee relationship to facilitate effective learning and growth in supervision.

B. Developmental Models of Supervision

In general, developmental models of supervision define progressive stages of supervisee development from novice to expert, each stage consisting of discrete characteristics and skills. For example, supervisees at the beginning or novice stage would be expected to have limited skills and lack confidence as counselors, while middle stage supervisees might have more skill and confidence and have conflicting feelings about perceived independence/dependence on the supervisor. A supervisee at the expert end of the developmental spectrum is likely to utilize good problem-solving skills and be reflective about the counseling and supervisory process (Haynes, Corey, & Moulton, 2003).

For supervisors employing a development approach to supervision, the key is to accurately identify the supervisee's current stage and provide feedback and support appropriate to that developmental stage, while at the same time facilitating the supervisee's progression to the next stage (Littrell, Lee-Borden, & Lorenz, 1979; Loganbill, Hardy, & Delworth, 1982; Stoltenberg & Delworth, 1987). To this end, a supervisor uses an interactive process, often referred to as "scaffolding" (Zimmerman & Schunk, 2003), which encourages the supervisee to use prior knowledge and skills to produce new learning. Throughout this process, not only is the supervisee exposed to new information and counseling skills, but the *interaction* between supervisor and

supervisee also fosters the development of advanced critical thinking skills. While the process, as described, appears linear, it is not. A supervisee may be in different stages simultaneously; that is, the supervisee may be at mid-level development overall, but experience high anxiety when faced with a new client situation.

1. Integrated Development Model: One of the most researched developmental models of supervision is the Integrated Developmental Model (IDM) developed by Stoltenberg (1981) and Stoltenberg and Delworth (1987) and, finally, by Stoltenberg, McNeill, and Delworth (1998) (Falender & Shafranske, 2004; Haynes, Corey, & Moulton, 2003). The IDM describes three levels of counselor development:

    - Level 1 supervisees are generally entry-level students who are high in motivation, yet high in anxiety and fearful of evaluation;
    - Level 2 supervisees are at mid-level and experience fluctuating confidence and motivation, often linking their own mood to success with clients; and Level 3 supervisees are essentially secure, stable in motivation, have accurate empathy tempered by objectivity, and use therapeutic self in intervention. (Falender & Shafranske)

    As noted earlier, the IDM stresses the need for the supervisor to utilize skills and approaches that correspond to the level of the supervisee. So, for example, when working with a level-1 supervisee, the supervisor needs to balance the supervisee's high anxiety and dependence by being supportive and prescriptive. The same supervisor when supervising a level-3 supervisee would emphasize supervisee autonomy and engage in collegial challenging. If a supervisor was to consistently mismatch his/her responses to the developmental level of the supervisee, it would likely result in significant difficulty for the supervisee to satisfactorily master the current developmental stage. For example, a supervisor who demands autonomous behavior from a level-1 supervisee is likely to intensify the supervisee's anxiety.

2. Ronnestad and Skovholt's Model

    In the most recent revision (2003), the model is comprised of six phases of development. The first three phases (*The Lay Helper, The Beginning Student Phase,* and *The Advanced Student Phase*) roughly correspond with the levels of the IDM. The remaining three phases (*The Novice Professional Phase, The Experienced Professional Phase,* and *The Senior Professional Phase*) are self-explanatory in terms of the relative occurrence of the phase in relation to the counselor's career. In addition to the phase model, Ronnestad and Skovholt's (2003) analysis found 14 themes of counselor development. These are:

1. Professional development involves an increasing higher-order integration of the professional self and the personal self
2. The focus of functioning shifts dramatically over time from internal to external to internal.
3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.
4. An intense commitment to learning propels the developmental process.
5. The cognitive map changes: Beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise.
6. Professional development is long, slow, continuous process that can also be erratic.
7. Professional development is a life-long process.
8. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.
9. Clients serve as a major source of influence and serve as primary teachers.
10. Personal life influences professional functioning and development throughout the professional life span.
11. Interpersonal sources of influence propel professional development more than 'impersonal' sources of influence.
12. New members of the field view professional elders and graduate training with strong affective reactions.
13. Extensive experience with suffering contributes to heightened recognition, acceptance and appreciation of human variability.
14. For the practitioner there is a realignment from self as hero to client as hero.

C. Integrative Models of Supervision

Haynes, Corey, and Moulton describe two approaches to integration: technical eclecticism and theoretical integration.

1. Technical eclecticism tends to focus on differences, chooses from many approaches, and is a collection of techniques. This path calls for using techniques from different schools without necessarily subscribing to the theoretical positions that spawned them. In contrast, *theoretical integration* refers to a conceptual or theoretical creation beyond a mere blending of techniques. This path has the goal of producing a conceptual framework that synthesizes the best of two or more theoretical approaches to produce an outcome richer than that of a single theory. (Haynes, Corey, & Moulton, p. 124).

2. Bernard's Discrimination Model: Today, one of the most commonly used and researched integrative models of supervision is the Discrimination Model, originally published by Janine Bernard in 1979. This model is comprised of three separate foci for supervision (i.e., intervention, conceptualization, and personalization) and three

possible supervisor roles (i.e., educator, counselor, and consultant) (Bernard & Goodyear, 2009). The supervisor could, in any given moment, respond from one of nine ways (three roles x three foci). For example, the supervisor may take on the role of educator while focusing on a specific intervention used by the supervisee in the client session, or the role of counselor while focusing on the supervisee's conceptualization of the work. Because the response is always specific to the supervisee's needs, it changes within and across sessions.

3. Systems Approach: In the systems approach to supervision, the heart of supervision is the relationship between supervisor and supervisee, which is mutually involving and aimed at bestowing power to both members (Holloway, 1995). Holloway describes seven dimensions of supervision, all connected by the central supervisory relationship. These dimensions are: the functions of supervision, the tasks of supervision, the client, the trainee, the supervisor, and the institution (Holloway). The function and tasks of supervision are at the foreground of interaction, while the latter four dimensions represent unique contextual factors that are, according to Holloway, covert influences in the supervisory process. Supervision in any particular instance is seen to be reflective of a unique combination of these seven dimensions.

D. Reflective Supervision:

The three building blocks of reflective supervision—reflection, collaboration, and regularity—are outlined below. {The author 's description reflects a child/family context.}

1. Reflection

   Reflection means stepping back from the immediate, intense experience of hands-on work and taking the time to wonder what the experience really means. What does it tell us about the family? About ourselves? Through reflection, we can examine our thoughts and feelings about the experience and identify the interventions that best meet the family's goals for self-sufficiency, growth and development.

   Reflection in a supervisory relationship requires a foundation of honesty and trust. The goal is to create an environment in which people do their best thinking—one characterized by safety, calmness and support. Generally, supervisees meet with supervisors on a regular basis, providing material (like notes from visits with families, videos, verbal reports, etc.) that will help stimulate a dialogue about the work. As a team, supervisor and supervisee explore the range of emotions (positive and negative) related to the families and issues the supervisee is managing. As a team, they work to understand and identify appropriate next steps.

   Reflective supervision is not therapy. It is focused on experiences, thoughts and feelings directly connected with the work. Reflective supervision is characterized by

active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee to answer her own questions, and to provide the support and knowledge necessary to guide decision-making. In addition, the supervisor provides an empathetic, nonjudgmental ear to the supervisee. Working through complex emotions in a "safe place" allows the supervisee to manage the stress she experiences on the job. It also allows the staff person to experience the very sort of relationship that she is expected to provide for clients and families.

2. Collaboration

   The concept of collaboration (or teamwork) emphasizes sharing the responsibility and control of power. Power in an infant/family program is derived from many sources, among them position in the organization, ability to lead and inspire, sphere of influence and network of colleagues. But most of all, power is derived from knowledge—about children and families, the field, and oneself in the work. While sharing power is the goal of collaboration, it does not exempt supervisors from setting limits or exercising authority. These responsibilities remain firmly within the supervisor's domain. Collaboration does, however, allow for a dialogue to occur on issues affecting the staff person and the program.

3. Regularity

   Neither reflection nor collaboration will occur without regularity of interactions. Supervision should take place on a reliable schedule, and sufficient time must be allocated to its practice. This time, while precious and hard to come by, should be protected from cancellation, rescheduling, or procrastination. That said, everyone working in infant/family programs knows that there are times when scheduling conflicts or emergencies arise, making it necessary to reschedule supervision meetings. When this happens, set another time to meet as soon as possible. If the need to reschedule arises frequently, it makes sense to consider why this is happening. Is the selected time an inconvenient one? Is the supervisor or the staff member overburdened, or is either having difficulty with time management skills? Is there some tension in the staff/supervisory relationship prompting either party to postpone their meeting?

   It takes time to build a trusting relationship, to collaborate, and to share ideas, thoughts, and emotions. Supervisory meetings are an investment in the professional development of staff and in the future of the infant/family program. Staff will take their cues from leaders: do program directors make time for supervision? Do the program's leaders "walk the talk"?

   Excerpted from Parlakian, R. (2001). Look, listen, and learn: Reflective supervision and relationship-based work. Washington, D.C: ZERO TO THREE.

E. Reflective Supervision Infant Mental Health

Professionals who provide services to infants and young children and their families involved in child protective services face multiple daily challenges. Working with stressed and traumatized infants/young children and their families, as well as the systems charged with providing services and oversight, affects professionals on many levels. These early professionals (mental health providers, developmental specialists, early interventionists, home visitors, family educators, Head Start teachers, public health nurses, child welfare workers and others) in turn require support and ongoing professional development to provide perspective, increase their skills, and avoid burn-out. Reflective supervision, a practice that has evolved from the multi-disciplinary field of infant mental health, provides the support needed by practitioners who are exposed to the intense emotional content and life experiences related to their work with families. An ongoing professional development process, reflective supervision provides a way for professionals working with very young children to reach greater understanding of their own responses, as well as the babies and adults they work with, and as a result, facilitating quality practice and intervention.

For more information:

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Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco: Jossey-Bass. Ward, C. C

V. Clinical Supervision-Methods and Types

A. Methods of Clinical Supervision

1. In person clinical supervision is defined as the supervisee and supervisor face-to-face in same physical setting.

2. Tele supervision is defined as utilization of HIPPA compliant teleconferencing technology such as ZOOM platform that provides face-to-face supervision with a supervisee and supervisor. This can be either individual or group. Utilization of telephone or email can complement this type of supervision. Although this type of supervision was initially employed in rural and frontier settings, where the supervisee and supervisor may be physically located some distance from each other, this has more recently been applied in urban settings as well. Encryption should be utilized at all times with attention to licensure and interstate boundaries regarding location of the supervisor and supervisee. It is important to check with your state professional board regarding rules allowing tele supervision. (See Appendix F)

B. Type of Clinical Supervision

1. Individual Clinical Supervision: Clinical individual supervision is defined as one supervisee and one supervisor in face-to-face supervision. It is important to check with your state professional board regarding numbers of hours required in individual supervision.

2. Group Supervision: Clinical group supervision is defined as two or more supervisees in face to face supervision with one supervisor. It is important to check with your state professional board regarding numbers of hours allowed or required in group supervision and the size of the group permitted.

3. Interdisciplinary supervision in behavioral health is defined as receiving clinical supervision from someone in someone who is not in your profession such as a social worker receiving supervision from a licensed clinical psychologist, psychiatrist or licensed professional clinical counselor. It is important to check with your state professional board regarding rules allowing interdisciplinary supervision and the number of hours allowed. (See Appendix F.)

C. References:

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VI. C**linical Supervision Session: BRIDGING FORM**

This form may be utilized to facilitate the supervisory alliance between supervisor and supervisee and provide them with essential feedback to enhance supervision.

Supervisee: Date:

Part A (To be completed shortly after supervision session)

1. What stands out to you about our last supervision? Thoughts, feelings, insights?

_____

_____

_____

2. On a 10 point scale, how would you rate the following items: (a to d)

Not at all Much		A little bit		Moderately		Much		Very Much
1	2	3	4	5	6	7	8	9 10

a) Helpfulness/effectiveness of supervisor: _____

What was helpful?

_____

_____

What was not helpful?

_____

_____

b) How connected you felt to your supervisor: ___

c) How engaged/involved you felt with the topics being discussed: __

d) How present you were in the supervision: ___

3. What would have made the supervision more helpful or a better experience?

_____

4. What issues came up for you in the supervision that are similar to your daily life problems?

5. What risks did you take in supervision?

Part B (to be completed just prior to the next supervision session)

1. What were the high and low points of your clinical work this week?

2. What items, issues, challenges or positive changes do you want to put on the agenda for our next supervision?

3. How open were you in answering the above questions? (0 to 100%)

4. Anything else you'd like to add

VII. Behavioral Health Integration

A. Integration and collaborative care are often used when discussing health care innovation and delivery. Three levels of collaborative care can be described as coordinated care, co-located care, and integrated care (Hunter, Goodie, Oordt, & Dobmeyer, 2017). In coordinated care the providers will share information at a distance and as needed. In co-located care the providers are in close proximity and collaboration is more common, but each provides services in traditional roles. Truly integrated care has providers working in seamless service delivery models with high level collaboration between disciplines, shared information systems, and common work spaces. Hunter, Goodie, Oordt, and Dobmeyer (2017) use an example of the primary care behavioral health model to provide examples of integrated behavioral health services. This model is a truly integrated behavioral health provider working alongside of primary care providers. The model allows for quick screening and interventions and is specifically designed to not impede the fast pace of primary care. Other models include integration of primary care providers into traditional specialty behavioral health services. Behavioral health providers that have only worked in specialty behavioral health will face new challenges as integration becomes more of a reality (Robinson & Reiter, 2013). Understanding levels of integration, collaboration, co-location, and team-based care will certainly be important tools for clinical supervision. The ability to provide clinical supervision in multiple environments, populations, and varying levels of integrated behavioral health services are crucial as innovation in health care continues.

B. Tools:
   1. Five Levels of Integration

      Self-Assessment Tool: Five Levels of Behavioral Health Integration

   2. A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers

      A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers

C. References

Hunter, C. L., Goodie, J. L., Oordt, M.S., & Dobmeyer, A. C. (2017). *Integrated behavioral health in primary care; Step-by-step guidance for assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.

Robinson, P. J., & Reiter, J. T. (2013). *Behavioral consultation and primary care* (2nd ed.). Switzerland: Springer International Publishing.

VIII. Where to locate training approved for CEU's

The approved trainings to meet various professional continuing education requirements vary by the relevant Boards. Here are some leads to possible courses.

For Psychologists:

New Mexico Psychological Association (online CE courses)
https://www.nmpsychology.org/page/33

American Psychological Association (continuing education programs)
http://www.apa.org/education/ce/index.aspx

National Register of Health Service Psychologists (member-only)
https://www.nationalregister.org/member-benefits/continuing-education/

For Social Workers:

National Association for Social Workers New Mexico
https://naswnm.org/

APPENDICES
Contents

Appendix A: Evaluation Tools

Several tools for evaluation of the supervisor and supervisee exist. Various examples are offered below to facilitate the evaluation and development of the supervisee. In addition, the competencies of the supervisor are critical. Thus, a self-assessment for the supervisor is offered to promote ongoing competency development. These documents may be modified according to organization requirements as well as consideration of the supervisory model (e.g., process, competency-based, CBT, psychodynamic, etc.) being applied in practice.

- Therapist Evaluation Checklist:
http://www.cfalender.com/assets/therapist-evaluation-checklist1.pdf

- Supervisor Evaluation Form

http://cfalender.com/assets/supervisor-evaluation-form3.pdf

- Supervisor Competency Self-Assessment

http://societyforpsychotherapy.org/wp-content/uploads/2016/10/Appendix-Special-Feature.pdf

- Key Areas for Evaluation of Clinical Supervision form:

This tool is intended to be used as a framework and guide for clinical supervision. The intent is to provide feedback to supervisors regarding their quality of supervision. The tool is broken up into two sections: Specific skills competencies, and Theoretical models. To best use this tool, a supervisor will record a supervision session with their supervisee, after obtaining the supervisee's consent. The session will be reviewed with the supervisor during a supervisors' group meeting. All supervisors participating in this meeting will receive a copy of this tool and rate each domain as the pre-recorded session is being viewed. The supervisor is encouraged to share feedback, answer questions, and rate themselves during this process. Please note that this process is intended for growth and support and should be done through a strengths based approach.

Key Areas for Evaluation of Clinical Supervision

COMPETENCIES	RATINGS / COMMENTS			
	Comment	Exemplary	Standard	Unaccept-able
Supervisor's communication uses counselling interventions with supervisee, such as:				
a. Open-ended questions				
b. Closed questions				
c. Paraphrasing				
d. Summarization				
e. Reflection of feelings				
f. Tuning into nonverbal language				
g. Information giving				
i. Use of Motivational Interviewing				
j. Problem identification				

COMPETENCIES	RATINGS / COMMENTS			
	Comment	**Exemplary**	**Standard**	**Unaccept-able**
Supervisor's communication uses counselling interventions with supervisee, such as:				
k. Mutual goal setting				
l. Use of humor, role playing, etc.				
m. Creating therapeutic climate/alliance (e.g. trust, rapport)				
n. Overall empathy				
o. Skillful feedback				
p. Focuses/connects to professional development				
q. Ensures that service to client is safe, ethical and competent				
r. The capacity to recognize and facilitate the co-evolving relationships between the worker-client and supervisor-worker-client relationships, identifying and addressing problems that arise. Explore various relationships of staff; supervisor/staff; management, etc and issues are addressed as needed.				

COMPETENCIES	RATINGS / COMMENTS			
	Comment	**Exemplary**	**Standard**	**Unacceptable**
Supervisor's communication uses counselling interventions with supervisee, such as:				
s. Culturally sensitive approach				
t. Knowledge of the service delivery protocol and treatment standards as well as the ethical mandates of relevant professional bodies and the ability to provide such information, as relevant in supervisory session.				
u. Use of supervision log constantly				
v. Advanced knowledge of the major issues experienced by clients (e.g. mental illness, alcoholism, drug abuse)				
w. Emphasis on self-care/staff wellness				
x. Supervisor has printed and brought to supervision, Caseload Performance Report and referred to it during supervision session.				

MODELS OF SUPERVISION MATRIX	
MODELS	**COMMENTS**
Psychotherapy-based Models of Supervision	
Psychodynamic Approach to Supervision	
Supervisee-Centered Psychodynamic Supervision	
Supervisory-Matrix-Centered Approach	
Cognitive-Behavioral Supervision	
Person-Centered Supervision	
Developmental Models of Supervision	
Integrated Development Model	
Ronnestad and Skovholt's Model	
Integrative Models of Supervision	
Technical Eclecticism	
Bernard's Discrimination Model	
System's Approach	
Reflective Practice/Supervision	

- Supports self-reflections of the supervisee.	
- Discusses awareness of one's individual and cultural beliefs, values and biases.	
- Continues to provide feedback during collaboration.	
Use of Self	
- Supports supervisee's initiation of ideas.	
- Expects the supervisee to have clear, rationales for theoretical approach.	
- Discusses and plans how to talk to parents about the strengths and vulnerabilities of their child.	
- Continues to give direct input and evaluative feedback.	

Appendix B:

Treat First Approach Tip Sheets:

Practice Tips & Clinical Techniques

ADDENDA - TIP SHEETS

Purpose of the Tip Sheets

The Treat First Approach Overview introduces several core practice functions and clinical techniques that can support effective clinical work with persons requesting assistance -- both during and after the first four visits in an episode of care. These Tip Sheets are offered in the spirit of practice development and intended to promote building of craft knowledge needed by frontline practitioners when implementing a Treat First Approach in their agencies.

Tip Sheets define expected outcomes to be achieved when a practice or technique is used and introduce important concepts and strategies related to the practice or technique. Tip Sheets are not meant to serve as a substitute for necessary training and development of staff competencies required to perform these practices and techniques. Rather, Tip Sheets are meant to alert provider staff members and agency leadership that frontline practitioners require the craft knowledge necessary to perform these practices and techniques as well as the organizational supports necessary to integrate them into their everyday work.

Tip Sheets - Title and Order of Presentation

The Tip Sheets are titled and organized as follows on pages 8 through 15:

- Practice Area: Recognition, Connection, and Rapport
- Practice Area: Engagement and Commitment
- Practice Area: Detection and Rapid Response
- Practice Area: Assessment and Formulation
- Practice Area: Wellness and Recovery Goals
- Practice Area: Teamwork - Common Purpose and Unity of Effort
- Clinical Technique: Solution Focused Brief Therapy
- Clinical Technique: Motivational Interviewing

Readers should note that practice areas listed above are core practice functions described in a general framework used for training, supervision, and measurement of practice. That framework is illustrated in the diagram appearing on page 2.

PRACTICE AREA: RECOGNITION, CONNECTION, RAPPORT

Desired Outcomes of Practice

RECOGNITION, CONNECTION & RAPPORT: • The person's sense of identity, culture, values and preferences, social network, and life experiences are recognized by practitioners involved with the person. • Any barriers to personal connection and acceptance are recognized and resolved. • Necessary conditions for building mutual respect and rapport are established as a basis for successful engagement.

Key Concepts

As an early step in building a relationship with a person entering services, practitioners recognize the nature of the person's situation and life story. Recognition involves discovering the circumstances that have brought the person into agency services and anticipating the life changes necessary for the person to make in order to conclude services successfully. Practitioners recognize the person's sense of identity, culture, values and preferences (especially any arising from religious conviction), social and economic supports, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, addiction, emigration, poverty) that explain the person's life story and reasons for entry into services. An important element in the process is recognition of any barriers that could thwart formation of positive connections with the person that could undermine acceptance and rapport building necessary for successful engagement. Successful practitioners take steps for creating conditions necessary for building mutual respect and rapport required in developing trust-based working relationships.

Recognition of a person's identity requires varying degrees of cultural responsiveness, depending on the person involved. Every person has his/her own unique identity, values, beliefs, and world view that shape ambitions and life choices. Some persons may require use of culturally relevant and responsive supports in order to successfully connect, educate, assist, and support them moving through the system. Responsiveness includes valuing cultural diversity, understanding how it impacts family functioning in a different culture, and adapting service processes to meet the needs of culturally diverse groups of persons receiving services. Properly applied in practice, cultural responsiveness reduces the likelihood that matters of language, culture, custom, identity, value, or belief will prevent or reduce the effectiveness of life change efforts undertaken via interventions, supports, and services.

Making sensitive cultural accommodations, where needed, involves a set of strategies used by practitioners to individualize the service process to improve the goodness-of-fit between the person (and the person's supporters) and service providers who work together in the wellness / recovery process. Many persons may require simple adjustments due to differences between the persons and their providers. Such simple adjustments are a routine part of engagement, assessment, planning, and service provision. A person's identity [e.g., race, tribe, ethnicity, social group; sexual orientation; religion; or disability, such as deaf] may shape his or her world view and life goals in ways that must be understood and accounted for in practice. Recognition, connection, and rapport provide a foundation for building and sustaining trust-based working relationships.

Practice Tips

1. LEARN THE REASON the person is seeking help. CONSIDER whether the person's problem can be RESOLVED IN A SINGLE VISIT OR A BRIEF INTERVENTION. DISCERN whether the person's problem is emergent/transient or serious/persistent. DETERMINE whether the reported problem is a present THREAT TO HEALTH OR SAFETY so that any need for crisis intervention or urgent response can be identified and provided.

2. If the person reports being in physical pain or emotional distress, ASK ABOUT its nature, source, history, and impact on the person's life situation. Use the person's responses to form a theory that explains how the pain or distress came about, what causes it to continue, what has been done to alleviate it in the past, what has worked/not worked before, and who else may be helping the person relieve or solve this problem now. *Note: Recognition & Rapport and Detection & Response are performed concurrently by the practitioner when a person is entering services.*

3. In early interactions, DISCOVER the person's sense of identity, culture, values and preferences (especially any arising from religious conviction), world view, social and economic supports, strengths and needs, present life challenges, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, recent loss, addiction, emigration, poverty) that explain the person's situation and reasons for requesting help.

4. IDENTIFY the person's LANGUAGE & CULTURE. DISCERN any impact that cultural or language differences may play in building rapport and forming a working relationship with the person. RECOGNIZE any barriers (arising from culture, language, gender, class, religious or political beliefs, life experiences, sexual orientation, work or family demands, or disability) that could thwart or limit the formation of positive connections with the person that would undermine acceptance and rapport building necessary for developing successful trust-based working relationships.

5. TAKE ACTIVE STEPS in establishing positive conditions for building MUTUAL RESPECT AND RAPPORT with the person.

PRACTICE AREA: ENGAGEMENT & COMMITMENT

Desired Outcomes of Practice

ENGAGEMENT & COMMITMENT. • Service providers are building and maintaining a trust-based working relationships with the person and the person's informal supporters to involve them in ongoing assessment, service planning, and wellness and recovery efforts. • Service providers are using effective outreach and ongoing engagement strategies to increase and sustain the person's participation in the service process and commitment to life changes that support wellness and recovery, consistent with the person's needs and preferences.

Key Concepts

Effective wellness and recovery services depend on effective working relationships between a person in need and the service providers who help meet those needs. Service providers make concerted efforts to reach out to the person, engage him/her meaningfully in all aspects of the service process, establish and maintain a trust-based working relationship, and secure and sustain the person's commitment to a change process. Engagement strategies build a mutually beneficial partnership in decision-making and life change efforts. The person's direct, ongoing, active involvement is used in assessment, planning interventions, selecting providers, monitoring and modifying service plans, and evaluating results. Engagement strategies vary according to the needs of the person and should reflect the person's language and culture.

Building Trust-Based Working Relationships. Building upon recognition of the person's identity, reason for seeking services, and a positive rapport, ongoing engagement efforts are used to form and maintain a trust-based, mutually beneficial working relationship between the person and those serving the person. Practice approaches that support effective relationship building are:

- Person-centered (organizes around the person's goals)
- Strengths-based (builds on the person's positive assets)
- Solution-focused (moves from problems to solutions)
- Need-responsive (recognizes and responds to needs)
- Wellness-oriented and outcome-driven (starts with the end in mind)
- Building readiness for change (uses motivational interviewing strategies)
- Fits the person's stages of change (starts where the person is ready)
- Respect for the person's identity, culture, aspirations, and preferences

In the absence of a trust-based working relationship with the service provider, the person is unlikely to reveal the underlying issues that explain the dynamic circumstances causing the problem that must be solved in order to achieve desired wellness and recovery outcomes.

Building Commitment to Positive Life Change. A major contribution of effective engagement is the person's ongoing commitment to personally choose wellness and recovery outcomes and to the change process used to achieve these outcomes. In the absence of the person's commitment to life change, wellness and recovery outcomes are not likely to be achieved.

Practice Tips

1. Remember that building a relationship with a person involves recognizing the nature of the person's life situation and reasons for requesting help. LISTENING is key to learning, empathy, respect, and trust building. Finding and overcoming any barriers to personal connections are essential. Recognition and rapport provide a foundation for building and sustaining a trust-based working relationship.

2. Use a person-centered approach that puts the person's voice and choice at the center of the service process. Recognize and respond to the person's unmet needs related to wellness, well-being, and daily functioning. Use a solution-focused approach that is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought the person to seek help. Solution-focused practice aims to bring about desired change in the least amount of time. [Tenets of solution-focused practice include: If it's not broken, don't fix it. If it works, do more of it. If it's not working, do something different rather than just trying harder. A solution is not necessarily related to the perceived problem. Small steps in the right direction can lead to big changes.] A strengths-based practice approach emphasizes a person's self-determination and strengths. Identify and build on the person's strengths and assets to create sustainable resources for solutions.

3. Change-oriented approaches are especially useful in addressing lifestyle modification for disease prevention, long-term disease or disorder management, and addiction. Understanding a person's readiness to make change, appreciating barriers to change, and helping anticipate relapse can improve the person's satisfaction and lower practitioner frustration during the change process. A stages of change approach is useful in stimulating change and overcoming resistance

4. Remember that engagement is an ongoing process that builds and sustains: 1) a mutually beneficial trust-based working relationship between the person and 2) a person's commitment to personally selected wellness and recovery outcomes and to the life change process.

PRACTICE AREA: DETECTION & RAPID RESPONSE

Desired Outcomes of Practice

DETECTION & EARLY RESPONSE. • A person who is at risk of harm due to safety, health, or situational threats is detected via screening and other means and then kept safe from harm by using rapid response strategies to mitigate risks and protect the person from imminent threats to the person's well-being.

Key Concepts

Detection. Upon admission, screening is performed to identify a person who may have an imminent threat of harm from life partners, caregivers or who may have an undiagnosed health or behavioral condition or who may be at high risk of developing a condition requiring treatment. A person should be screened upon admission and periodically thereafter for certain life situations, conditions, and disorders that may require diagnosis, treatment, and ongoing care. Life situations, conditions, disorders, or diseases for which screening should be routinely performed include:

- Safety/threats of harm at home
- Adverse childhood experiences/complex trauma
- Emotional status/behavioral disorders
- Health status/physical well-being/illness
- Inappropriate or unstable living situation
- Self-endangerment/threats of harm to others
- Intellectual or developmental disability/TBI/learning problems
- Drug/alcohol use/substance use disorder
- Diseases: diabetes, COPD, obesity, hypertension, seizures
- A pattern of instability or a trajectory of physical or emotional decline

Other agencies and practitioners involved in providing services to the person should be identified and contacted to provide necessary opportunities for service delivery, coordination, and integration.

Rapid Response

Rapid Response. Following detection of a threat of harm or an emergent condition, a response is an action taken to avert a safety threat, stop the progression of a disease, control a behavioral disorder, or to mitigate preventable injury or illness. A timely and appropriate response is provided for any person who is detected via a screening process as has having a condition, disorder, or disease for which intervention or treatment is indicated.

A Rapid Response [following the detection of a serious threat or rapidly developing condition]: a response commensurate with the urgency, severity, and intensity of a detected problem, especially when the person is at imminent risk of harm (e.g., sudden death via suicide) or at high risk of a poor health outcome (e.g., a brittle diabetic adolescent who violates dietary restrictions).

Practice Tips

1. Screenings of the person are performed upon admission and periodically thereafter. Practitioners continue to conduct screenings to detect safety, health, and behavioral risks as well as any emergent conditions or disorders as an ongoing assessment process.

2. Based on results of screenings and self-reports by the person, any problems of significance (involving safety, health, or behavioral risks or other situations that could lead to instability or decline) are promptly detected. The nature, significance, and history of any detected problem are defined and reported to any other practitioners or agencies that should be involved in providing an appropriate response to the person's need for prevention, protection, treatment, or care.

3. Any problem requiring a crisis intervention or urgent response is addressed in a timely, appropriate, and sufficient manner so as to prevent unnecessary harm, pain, loss, or hardship for the person. Each response provided is commensurate with the urgency and severity of the presenting problem. Any response provided protects the person from preventable harm or mitigates the impact the problem would have likely had if not treated promptly and effectively.

4. Results of initial and ongoing screenings are incorporated into the ongoing bio-psycho-social assessment and clinical understanding/case formulation of the person's situation. Any significant screening and detection results are used to develop necessary protective interventions and/or treatments to keep the person safe, physically and behaviorally healthy, and functioning effectively in daily life.

PRACTICE AREA: ASSESSMENT & FORMULATION

Desired Outcomes of Practice

ASSESSMENT & FORMULATION. • Ongoing formal and informal fact finding methods are used to develop and update a broad-based understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. • An evolving clinical case formulation (describing the person's clinically significant distress and impairment in functioning) is used to guide development of treatment plans informed by the person's life stage, culture, social context, and preferences.

Key Concepts

Ongoing assessment and clinical case formulation guide the course of action designed and used by service providers to help a person meet wellness and recovery goals that he/she has selected. Assessment processes are used to gather facts and assemble information and knowledge for developing a functional understanding of the person's situation and desired life change outcomes. Assessment provides answers to practical and clinical questions [see the separate list of clinical questions] that are used to develop a working understanding for the person from which treatment decisions are made. Based on the working understanding, a clinical case formulation is developed and updated as new understandings emerge. The formulation is used in developing a course of action (treatment and supports) for meeting the person's wellness and recovery goals.

Assessment & Understanding. As appropriate to the person's situation, a combination of clinical, functional, and informal assessment techniques are used to determine the strengths, needs, risks, underlying issues, and future goals of the person. Once gathered, the information is analyzed and synthesized to form a functional understanding and a bio-psycho-social clinical formulation used in developing a course of action for the person. Assessment techniques, both formal and informal, are appropriate for the person's life stage, ability, culture, language or system of communication, legal issues, and life situation. Areas in which essential understandings are developed include:

- Earlier life traumas, losses, and disruptions
- Learning problems affecting school or work performance
- Subsistence challenges encountered in daily living
- Risks of harm, abuse, neglect, intimidation, or exploitation
- Traumatic brain injury and/or intellectual disabilities
- Court-ordered requirements/constraints/detention
- Recent life disruptions (e.g., eviction, bankruptcy)
- Co-occurring life challenges (mental illness, addiction, domestic violence)
- Significant physical health and/or behavioral health concerns
- Recent tragedy, trauma (including combat trauma), losses, victimization
- Problems of attachment, bonding, self-protective boundaries in relationships
- Recent life changes (e.g., new baby, job loss) requiring major adjustments
- Any significant screening and detection findings (health or safety risks)
- Dislocation due to natural disaster or changes in the local job market

Case Formulation and Clinical Reasoning. Understandings developed from ongoing assessments are used to create a clinical case formulation that guides service decisions and actions. Clinical reasoning is applied in moving from understanding to action: Any compelling urgency is addressed first. Practical solutions may precede clinical solutions in the course of action. Plans develop from outcome to action. Opportunities for early and repeated successes are identified and pursued. A pace of action that could overwhelm the person is avoided.

Practice Tips

1. Remember that the outcome of assessment is an essential FUNCTIONAL UNDERSTANDING of the person used in case formulation to guide intervention planning. Assessment is a continuous learning process involving the person and service providers, not a form to complete upon intake or other points in the course of action. Assessment includes the gathering and assembly in facts, information, and knowledge to develop a broad-based understanding of the person's situation used to support decision making.

2. A clinical case formulation includes a clinical history and concise summary of the bio-psycho-social factors contributing to the present disorder. It focuses on clinically significant distress and impairment in functioning experienced by the person. The case formulation considers the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern.

3. Practical reasoning and clinical judgment are used in making a reliable assessment of factors related to a person's disruption in daily functioning or role fulfillment. Functional understandings and clinical case formulation are used to guide development of a comprehensive treatment plan, including support plans where indicated, informed by the person's life stage, culture, social context, and preferences.

4. Principles of person-centered practice and self-directed care are applied in all aspects of assessment and clinical case formulation.

PRACTICE AREA: WELLNESS & RECOVERY GOALS

Desired Outcomes of Practice

WELLNESS & RECOVERY GOALS: • Clearly stated, well-informed, and personally-selected wellness and recovery goals are developed with the person and used to guide intervention strategies toward attainment of desired levels of well-being, supports for living, daily functioning, inclusion, productivity, and role fulfillment for the person.

Key Concepts

WELLNESS is an active process in which a person becomes aware of and makes choices toward a more successful existence. Wellness is a conscious, self-directed, and evolving process of achieving full potential. Wellness is a multidimensional and holistic, encompassing lifestyle, mental and spiritual wellbeing, and the environment. Wellness is positive and affirming. [National Wellness Institute]

RECOVERY is a process through which persons improve their health and wellness, live a self-directed life, and strive to reach their full potential. Ten guiding principles of recovery are: hope, person-driven, many pathways, holistic, peer support, relational, culture, responsive to trauma, strengths and responsibility, and respect. [SAMHSA]

Consistent with the principles of person-centered practice, personally-selected wellness and recovery goals vary among persons having a wide range of personal needs, aspirations, and life trajectories reflective of their age, ability, and situation:

- A person experiencing a simple, acute problem, but having no systematic barriers or impediments, should improve quickly and reach desired levels of well-being, sustainable supports, daily functioning, and independence with minimal assistance and limited interventions.
- A person experiencing a chronic problem with minimal systematic barriers or impediments should achieve adequate levels of stability, functioning, and well-being while self-managing the condition as independently as possible until he/she requires more intensive temporary care or treatment. Once the person regains adequate levels of stability, functioning, and/or well-being, he/she resumes self-management of the condition with a lower level of ongoing monitoring and support from the system.
- A person having limited capacities and/or major systematic barriers or impediments should achieve and maintain his/her best attainable level of functioning, well-being, and support until his/her status changes. Persons having intellectual disabilities, serious and persistent mental illness, traumatic brain injury, and the frail elderly often require more intensive or specialized long-term care services.

Personal wellness and recovery goals specify: (1) Levels of well-being, supports, daily functioning, productivity, or social integration to be achieved by the person; (2) Aspirations for fulfilling life roles (e.g., employee, parent, life partner, grandparent) the person seeks to achieve including the manner and degree of accomplishment; and (3) Any requirements to be met (e.g., discharge from hospital or detention) before interventions are transitioned to either ongoing maintenance services (e.g., self-management with monitoring, reunification of children from foster care) or independence from the service system. Wellness and recover recovery goals define outcomes to be accomplished via services.

Practice Tips

1. Use person-centered planning techniques to help the person identify and state what he/she expects to gain or achieve from the service process. Frame these expectations as wellness or recovery goals using the person's own words. Make sure the goals selected for service planning are based on the person's assessed needs, expressed aspirations for wellness and recovery, and socially-beneficial choices.
2. Construct goals that are SMART: Specific, Measurable, Achievable, Relevant, and Time-bound. Clear goals help in planning intervention strategies and measurement of results. Relevant and achievable goals promote the person's motivation and commitment to the change process.
3. Consider the nature, purpose, trajectory, time required, person's motivation, and opportunities available for achieving the goals selected. Recognize that there may be an important order of priority in which goals are addressed. Any compelling urgencies should be addressed first.
4. Use the person's wellness and recovery goals to guide the selection of strategies to be used for their attainment. Identify goals for which the involvement of other practitioners or agencies will be involved in or responsible for the helping the person achieve the desired outcomes.
5. Use teamwork processes to build common purpose and unity of efforts with other supporters, practitioners, and agencies involved in helping the person achieve his or her wellness and recovery outcomes.

PRACTICE AREA: TEAMWORK / COMMON PURPOSE & UNITY OF EFFORT

Desired Outcomes of Practice

TEAMWORK / COMMON PURPOSE & UNITY OF EFFORT. • Using a shared-decision making process, the person and the person's practitioners and supporters are building and sustaining: • Common purpose by planning wellness/recovery goals and strategies together with the person. • Unity of effort in service delivery by coordinating actions of the person's providers and integrating services across providers, settings, time, and funding sources.

Key Concepts *[These Aspects of Practice are Applied to Persons Having Complex Needs and Ongoing Services]*

Person-centered practices and self-directed care principles put the person's needs, aspirations, and choices at the center of service organization. A team-based, shared decision-making process helps the person to create a vision for a better life based on aspirations for wellness, valued social roles, social inclusion, and successful daily living. Informal supporters and service providers join with the person (consistent with the person's preferences) to define wellness/recovery goals to be achieved along with related strategies for provision of supports and services. Because the efforts of many may be involved in helping the person, achieving common purpose and unity of effort are essential for success. Together, common purpose and unified efforts create the "glue" that holds things together in practice for the benefit of the person receiving services.

Common Purpose. Common purpose is created when the people involved agree upon and commit to clear goals and a related course of action. An ongoing, person-centered, team-based, shared decision-making process may be used to achieve and maintain a consensus on and commitment to a set of wellness/recovery goals and related strategies. These goals and strategies are determined by and with the person, the person's primary supporters, and the service providers involved. CONSENSUS and COMMITMENT are essential for building common purpose.

Unity of Effort. Unity of effort is based on: (1) A common understanding of the person's situation; (2) A common vision for the person's wellness or recovery; (3) Coordination of efforts to ensure coherency and continuity; (4) Common measures of progress and ability to change course, if necessary. Unity of effort is achieved and maintained via ongoing teamwork, coordination of actions among providers and supporters, and integration of services across providers, settings, funding sources, and points in time. Unity of effort is the state of harmonizing actions and efforts among multiple service providers and supporters who are commited to helping the person achieve agreed upon goals and shared outcomes.

Practice Tips

1. Remember that effective TEAMWORK and SERVICE COORDINATION help build common purpose and unity of effort in frontline practice. Effective teamwork involves having the right people working together with and for the person being served. The team should have the technical and cultural competence, knowledge of the person, authority to act on behalf of funding agencies and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person. NOTE: Persons having serious, persistent illnesses (requiring ongoing care and treatment) benefit most from effective teamwork and service coordination. Person-centered teams are useful for persons receiving multiple ongoing care and treatment services.

2. The person's team assists in conducting person-centered planning activities and in providing assistance, support, and interventions after plans are made in order to meet the person's wellness/recovery goals. Working together, team members support the person in identifying needs, setting wellness/recovery goals, and planning strategies with related services that will enable the person to meet those goals. Effective, ongoing, collaborative problem solving is a key indicator of effective team functioning.

3. Leadership and coordination are necessary to: (1) form a person-centered team and facilitate teamwork; (2) plan, implement, monitor, modify, and evaluate services provided; (3) integrate strategies, activities, resources, and interventions agreed to by the team; (4) measure and share results for the individual in order to change strategies that do not work and to determine progress; and (5) ensure a unified process involving a shared decision-making approach. While leading and coordinating may be appropriately discharged by a variety of team members, it is most effectively accomplished by a designated leader who prepares team members, convenes and organizes meetings, facilitates team decision-making processes, and follows up on commitments made. Individual(s) filling these roles should have strong facilitation skills, authority to act, and, as appropriate to role, clinical skills in assessing, planning, monitoring, and evaluation. In a case where several agencies and providers are involved, negotiation may be necessary to achieve and sustain a coordinated and effective service process. Leadership and coordination responsibilities can be shared with an empowered and capable service recipient. This may be an appropriate outcome of interventions for the person receiving services.

3. Team functioning and decision-making processes should be consistent with principles of person-centered practice and self-directed care. Evidence of effective team functioning over time is demonstrated by the quality of relationships built, commitments fulfilled, results achieved, unity of effort shown by all members of the team, the focus and proper fit of services assembled for the person, dependability of service system performance, and connectedness of the person to critical resources necessary for achieving wellness/recovery goals.

CLINICAL TECHNIQUE: SOLUTION FOCUSED BRIEF THERAPY

Desired Outcomes of Practice

SOLUTION FOCUSED BRIEF THERAPY: • The person's concerns and reasons for requesting help are clarified. • The person's aspirations and vision for a preferred future are stated. • The person demonstrates motivation and confidence in finding solutions. • The person's strengths and past successes are used to build solutions. • The person is taking small steps in the right direction toward a preferred future.

Key Concepts

A practice that may be useful in a Treat First Approach is Solution Focused Brief Therapy (SFBT) that focuses on a person's strengths and previous successes rather than failings and problems. SFBT consists of conversations that stimulate and support positive life change for a person receiving services. These conversations are centered on the person's concerns; who and what are important to the person; a vision of a preferred future; the person's exceptions, strengths, and resources related to the vision; scaling of the person's motivation level and confidence in finding solutions; and, ongoing scaling of the person's progress toward reaching the desired future. The goal is helping a person rapidly find a solution to a resolvable life problem. The basis for a brief intervention builds on the person's understanding of his/her concern or situation and what the person wants to be different in the future.

Basic concepts of SFBT are:

- It is based on solution-building, not problem-solving.
- It encourages the person to increase the frequency of useful behaviors.
- The person and provider create solutions based on what has worked in the past.
- It asserts that small steps in the right direction lead to larger changes.
- It is focused on the person's desired future, not the past.
- It assumes that solution behaviors already exist for the person.
- It places responsibility for change on the person.

SFBT has been recognized as an evidence-based practice and is listed on the SAMHSA National Registry of Evidence-Based Programs and Practices.

Solution-Focused Questions

Solution-focused questions about the topics of conversation are used to connect to and build on the concerns and aspirations expressed by the person. Examples of solution-focused questions include:

- Given the issue or problems you are faced with, what are you hoping we can achieve together?
- How would you like your life to change in regard to the issues we have been discussing?
- Are there things you have tried already to solve this problem?
- What are some things you have already accomplished that you are pleased with?
- What types of support do you have from family/community/resources?
- What personal traits, skills, and talents have helped you in the past?
- What personal qualities are helping you get through these difficult times right now?
- How is it you found the strength and wisdom to come here for help?
- What do you suppose you do or have done so that the problem isn't any worse?
- With such difficulties in your life, how have you been able to get up and face each day?
- How are your life and your functioning affected by having a diagnosis of _____?
- What have you tried in the past when confronted with these types of problems?
- Would this type of solution help with your situation now?
- When you have achieved your goal, what are some things you will experience that will let you know that your goal has been accomplished?
- If your problem suddenly went away, what would be the first thing you would notice about yourself (how would be feeling, thinking, doing)?
- How would those around you know that this big change had occurred?
- What will be different in your life when the problem is gone?

CLINICAL TECHNIQUE: MOTIVATIONAL INTERVIEWING

Desired Outcomes of Practice

MOTIVATIONAL INTERVIEWING: • The person is increasingly aware of the potential problems caused, consequences experienced, and risks faced as a result of a particular behavior. • The person envisions a better future and becomes increasingly motivated to achieve it.

Key Concepts: Motivational Interviewing is a Technique Used with Solution Focused Brief Therapy

Motivational interviewing is a method that works on facilitating and engaging intrinsic motivation within the person in order to change behavior. The examination and resolution of ambivalence is a central purpose and the practitioner is intentionally directive in pursuing this goal. Motivational interviewing is a semi-directive, person-centered counseling style for eliciting behavior change by helping a person to explore and resolve ambivalence. It is change-focused and goal-directed. Motivational interviewing is non-judgmental, non-confrontational and non-adversarial. Motivational interviewing recognizes and accepts the fact that persons who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. Some persons may have thought about it but not taken steps to change it or may be actively trying to change behavior and may have been doing so unsuccessfully for years. In order for a practitioner to be successful at motivational interviewing, four basic skills should first be established: 1) The ability to ask*open-ended questions*. 2) The capacity for *reflective listening*. 3) The ability to provide *affirmations*. 4) The ability to periodically provide *summary statements* to the person. The motivational approach attempts to increase the person's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Alternately, practitioners help the person envision a better future, and become increasingly motivated to achieve it. The strategy seeks to help the person think differently about their behavior and ultimately to consider what might be gained through change.

Motivational interviewing focuses on the present and entails working with a person to access motivation to change a particular behavior that is not consistent with a person's personal value or goal. *Warmth*, *genuine empathy*, and *unconditional positive regard* are necessary to foster therapeutic gain within motivational interviewing. The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment language from the person. A central concept is that ambivalence about decisions is resolved by conscious or unconscious weighing of pros and cons of making change versus not changing. It is critical to meet people where they are and to not force a person towards change when they have not expressed a desire to do so. The four general principles are:

1. **Express Empathy**. Empathy involves seeing the world through the person's eyes, thinking about things as the person thinks about them, feeling things as he or she feels them, sharing in the person's experiences. The practitioner's accurate understanding of the person's experience facilitates change.

2. **Develop Discrepancy**. This guides practitioners to help persons appreciate the value of change by exploring the discrepancy between how the person wants his or her life to be versus how it is currently (or between their deeply-held values and their day-to-day behavior). Practitioners work to develop this situation through helping persons examine the discrepancies between their current behavior and future goals.

3. **Roll with Resistance**. The practitioner does not fight a person's resistance, but "rolls with it." Statements demonstrating resistance are not challenged. Instead the practitioner uses the person's "momentum" to further explore his or her views. Using this approach, resistance tends to be decreased rather than increased, as persons are not reinforced for becoming argumentative. Motivational interviewing encourages persons to develop their own solutions to the problems that they themselves have defined.

4. **Support Self-Efficacy**. This guides practitioners to explicitly embrace the person's autonomy (even when persons choose to not change) and help the person move toward change successfully and with confidence. As persons are held responsible for choosing and carrying out actions to change, practitioners focus their efforts on helping people stay motivated, and supporting their sense of self-efficacy is a great way to do that.

Key points on Motivational Interviewing are:

- Motivation to change is elicited from the person and is not imposed from outside forces.
- It is the person's task, not the counselor's, to articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- The counseling style is generally quiet and elicits information from the person.
- The counselor is directive, in that they help the person to examine and resolve ambivalence.
- Readiness to change is not a trait of the person, but a fluctuating result of interpersonal interaction.
- The therapeutic relationship resembles a partnership or companionship.

Thus, motivational interviewing uses an ongoing conversation about life and change as a basis for engagement and encouragement.

Appendix C:

Case Discussion Guide for Reflective Practice

(This example is for a Child & Family Case. Can be modified for Adults)

INTRODUCTION

Purpose

The Discussion Guide is intended to create opportunities for reflective case practice discussions between caseworkers, practitioners, and supervisors.

The Discussion Guide may be most helpful when used to

- Identify successes and opportunities
- Affirm good practice when observed in the case
- Suggest options for overcoming any barriers encountered
- Provide assistance to the caseworker or care coordinator as needed
- Discover a worrisome case trajectory and plan actions accordingly

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QSR Practice Principles

In this example, the Discussion Guide uses five QSR Principles to assess areas of practice that are critical to attaining positive outcomes for children and families.

1. Engaging Service Partners	• Do you have a trust-based working relationship with the child, family, and other service providers?
2. Understanding the Situation	• Do all involved understand the child and family situation well enough to make a positive difference?
3. Planning Positive Life-Changing Interventions	• Is service planning an ongoing process, reflective of the current situation and helping to achieve desired outcomes for the child and family?
4. Implementing Services	• Are services appropriate to meet the need? • Is the implementation and coordination of services timely, competent, and of sufficient intensity to achieve desired outcomes?
5. Getting and Using Results	• Are current efforts leading to positive results? • Is knowledge gained through experience being used to refine strategies, solve problems, and move the case forward?

Using the Guide

Using the Discussion Guide is optional. It may be used in any format that accommodates the needs of the local office as long as it is helpful and affirming to frontline workers, practitioners, and supervisors.

1. ENGAGING THE CHILD AND FAMILY IN A CHANGE PROCESS

• Have you engaged the child, family, and other service partners in an ongoing trust-based working relationship?

Strength	Opportunity	Areas to Be Explored
		The team meets with the child and family face-to-face and identifies their strengths, needs, and underlying issues.
		The family has identified and communicated their strengths and needs to those who provide services.
		The family has stated how they believe their needs can be met.
		The child and family are engaged as active participants in the service process.
		The service team includes the important people in the child's life (school, medical, legal, juvenile court, mental health, other service providers, church, mentors, friends, extended family, others)
		Every service team member is committed to helping and achieving positive outcomes. There is a strong sense of urgency in meeting near-term needs and long-term goals evident in the attitudes and actions of team members.
		There is a reliable support network involved with this child and family.

Next steps to improve engagement:

2. UNDERSTANDING THE CHILD AND FAMILY SITUATION

• Does everyone on the service team understand the child and family well enough to improve their levels of well-being, daily functioning, sustaining supports, and role performance?

Strength	Opportunity	Areas to Be Explored
		The presenting problems and underlying issues are clearly identified and agreed upon by the service team.
		The child's functional status in daily settings is accurately assessed and understood in context by service team members.
		Any issues related to education, substance abuse, mental health, developmental or physical disabilities are diagnosed and understood.
		Known risks of harm (abuse, neglect, domestic violence, health crisis, suicide) are understood.
		A safety plan in place, used, as needed, and understood. The safety plan is evaluated and refined after each use.
		Any special needs, risks of harm, transition requirements, or needs for further assessments are understood and addressed effectively by the service team.
		The team clearly understands what things must change for the child and family to get better, do better, and stay better.
		All other interveners in the child's life participate in developing a 'big picture' understanding of the case situation.
		All other interveners are part of the service team and/or know what services are being provided.

Next steps to improve understanding of the child and family situation:

3. PLANNING POSITIVE LIFE-CHANGING INTERVENTIONS

• Is planning for the child and family an ongoing process that reflects the child's situation and what must change?

• Are planned interventions designed to meet near-term needs and long-term outcomes for the child and family?

Strength	Opportunity	Areas to Be Explored
		The child and family are engaged as active participants in the service planning process and have a trust-based relationship with those involved with them in the service process.
		The strategies and supports in the case plan are consistent with the strengths, needs and goals of the child and family.
		Focal problems, functional challenges, risks, and underlying issues are reflected in the choice of goals and strategies.
		The planning process includes family team conferencing.
		There is a long-term guiding view that focuses on the child living in a safe, appropriate and permanent home in the near future.
		Known transitions between settings, levels of care, providers and life stages are recognized are being addressed.
		The planning process is building sustainable supports (formal and informal) to enable the family to function safely after services are completed.
		Strategies, interventions, and supports are individualized to fit the child and family situation.
		All service team members support the service planning process.
		Treatment efforts are unified among providers.

Next steps to improve planning of services:

4. IMPLEMENTING STRATEGIES AND SUPPORTS TO GET RESULTS

• Is implementation of planned intervention strategies, supports, and services -- timely, competent, and of sufficient intensity, duration, and consistency to achieve the desired results?

Strength	Opportunity	Areas to Be Explored
		The child and family are engaged as active, ongoing participants in the service process.
		Supports, services, and interventions are implemented consistent with case plan goals, strategies and requirements.
		Supports, services, and interventions are provided in a timely, adequate, competent, and culturally-respectful manner by all service providers.
		The service team has timely feedback about services provided as well as about service problems encountered.
		Services are adjusted as a result of feedback received.
		The case plan is modified when goals are met, strategies are found not to work, or when circumstances change.
		Service team members are fulfilling their roles and responsibilities to insure desired outcomes.
		Safety/health procedures are implemented correctly and effectively.
		Concurrent planning, where indicated, is being implemented in a timely and appropriate manner.
		Service efforts are integrated and coordinated across providers to maximize benefits and reduce duplication.

Next steps to improve implementation of services:

5. GETTING AND USING POSITIVE RESULTS

- Are interventions leading to positive results and outcomes?
- Is knowledge of results being used to improve intervention efforts?

Strength	Opportunity	Areas to Be Explored
		Intervention strategies, supports, and services are tracked to detect any implementation problems and evaluated to determine their effectiveness in producing desired results.
		Positive changes are being observed in the problems that brought/keep the child and family in services.
		The child is demonstrating functional improvement in routine daily activities and academic performance.
		The family is demonstrating functional improvement in safe and dependable caregiving.
		Known risks of harm are being reduced or properly managed through effective strategies.
		Transition planning for the child is in process and effectively supporting any life changes and adjustments.
		An adequate, sustainable support network is being established that will stay with the family after case closure.
		Results are being used to shape strategy, solve problems, and determine readiness for step-down or case closure.

Next steps to improve results and use results to improve service efforts:

REFECTIONS ON PRACTICE IN THIS CASE

Successes in Achieving Results

- What supports, interventions, or engagement techniques are working now?
- In what observed ways are the child and family getting better, doing better, and staying better now?
- What makes current strategies and supports successful?
- Why is the family responding favorably to the service process?

Factors Limiting Progress or Results

- Are any child or family factors limiting progress in this case? If so, how?

- Are problems in accessing necessary intervention strategies, supports, and services for this child and family limiting progress in this case? If so, what are they?

- Are any local conditions of practice (e.g., caseload sizes, staff turnovers, vacancies, waiting lists, travel and distance issues) limiting progress in this case? If so, what are they?

Case Trajectory Concerns

- Are there any unfolding circumstances that could lead to harm, hardship, or poor down-stream outcomes for the child and family? Is so, what are they?

- What steps, if any, should be taken to improve the trajectory of this case and achievement of desired outcomes for this child and family?

Assistance to Move Case Practice Forward

- **Which of the following sources of assistance would help you most right now?**

Training – on the use of a new skill or technique related to this case.

Modeling and Mentoring – on the use of a new skill, technique, or role in this case.

Supervisor Assistance – in solving a case-specific problem.

Specialty Consultation – to conduct a specialized assessment or perform a complex intervention in this case.

Multi-Organization Support – to integrate information, coordinate planning and services across providers, and integrate funding sources in this case.

Other – assistance of a unique nature not covered above.

Appendix D

Clinical Reasoning Organizers

The following “Organizers” are discussed in Section 3. Clinical Supervision Preparation Tools.

Bio-Psycho-Social Worksheet

Note: This bio-psycho-social assessment organizer is used for noting historic & current factors that explain Mateo's present situation and state of need. Knowledge is used to answer clinical questions and plan a case formulation.

Key Factors	Biological Domain	Psychological Domain	Social Domain	
Explaining a Person's Life Circumstances/ Problems	**Genetic, developmental, medical, temperament, biological effects of substance use**	**Cognitive style, intra-psychic conflicts, defense mechanisms, self-image, meaning of symptoms**	**Social-relationships family/ peers/others**	**Social-environment cultural/ ethnicity, social risk factors**
1. Predisposing → (Vulnerabilities that tend to increase risks of the presenting problems)	[E.G: Family psychiatric history, toxic exposures in utero, birth complications, developmental disorders, regulatory disturbances, traumatic brain injury]	[E.G: Insecure attachment, problems with affect modula--tion, rigid or negative cognitive style, low self-image]	[E.G: Childhood exposure neglect or abuse, late adoption, temperament miss-match, marital conflicts]	[E.G: Poverty, low SES, teenage parenthood, poor access to health or mental health care]
2. Precipitating → (Stressors and life events having a time relationship with the onset of symptoms and may serve as triggers)	[E.G: Serious medical illness or injury, increasing use of alcohol or drugs]	[E.G: Conflicts around identity or separation-individuation arising at developmental transitions, such as puberty onset or graduation from high school]	[E.G: Loss or separation from close family member, loss of friendships, interpersonal trauma]	[E.G: Recent immigration, loss of home, loss of supportive services]
3. Perpetuating → (Ongoing life challenges and sources of needs)	[E.G: Chronic illness, functional impairment caused by cognitive defects or learning disorder]	[E.G: Use of self-destructive coping mechanisms, help-rejecting personality style, traumatic re-enactments]	[E.G: Chronic marital/ family discord, lack of empathy from parent, inappropriate parental expectations]	[E.G: Chronically dangerous neighborhood, trans-generational problems of immigration]
4. Protective → (Functional strengths, skills, talents, interests, assets, work, supportive elements of the person's relationships)	[E.G: Above-average intelligence, easy temperament, special talents or abilities, physical attractiveness, factors related to emotional intelligence]	[E.G: Ability to be reflective, ability to modulate affect, positive sense of self, adaptive coping mechanisms, other skills that build resiliency]	[E.G: Positive parent-child relation-ships, supportive community and extended family, family resources]	[E.G: Community cohesiveness, availability of supportive social network, well-functioning team]
5. Predictive → (Potential for change, areas most amenable to change as well as potential obstacles to positive change)	[E.G: Sustained good health -or- worsening illness, persisting pattern of sobriety or addiction]	[E.G: Adaptive to unfolding life changes -or- resistant to current change efforts]	[E.G: Supportive friends and family members -or- destructive friends or toxic family relationships]	[E.G: Positive supports for life changes -or- ongoing unsolved social issues or legal matters]

Clinical Questions Worksheet

Answers to Clinical Reasoning Questions Are Used to Guide Case Formulation and Intervention Planning

Presented below are clinical reasoning questions intended for use by practitioners, clinicians, and supervisors. These questions may be applied throughout a person's service process. **Answers to these questions can help guide the clinical case formulation** for a person receiving services as well as guide intervention planning, implementation, and completion of interventions. These questions work well in group supervision situations that involve case presentation and analysis.

1. **People Involved:** Who are the people involved in supporting and serving this person? How well are they engaged, involved, and committed to helping this person get better, do better, and stay better?

2. **Expectations:** What outcomes of intervention are people expecting to be achieved? The person? The family, life partner, and/or key supporters? The school or employer? The court? Service providers?

3. **Causes & Contributors of Presenting Problems:** What bio-psycho-social factors, life circumstances, and underlying issues explain the person's presenting problem(s) and current unmet needs?

4. **Risk Factors:** Based on history and tendencies, what things could go wrong in this person's life? What must be done to avoid or prevent future harm, pain, loss, or undue hardship?

5. **Functional Strengths & Assets:** What are the person's functional strengths, aspirations for change, and life assets that can be built up to solve the problem(s) that brought the person into services?

6. **Critical Unmet Needs:** What presently unmet needs would have to be fulfilled in order for this person to get better, do better, and stay better?

7. **Points of Consensus & Dispute:** On what key matters, if any, do the people involved agree at this time? What other key matters, if any, may be in dispute at this time? What impact, if any, are unresolved disputes having on decision-making about needs, risks, outcomes, interventions or commitments to the change process?

8. **Necessary Changes:** What things in the person's life would have to change in order for the person to achieve adequate well-being, have essential supports for living, function adequately in daily activities, and fulfill key life roles - as appropriate to life stage, capacities, and preferences?

9. **Essential Outcomes:** What life conditions, when met, will indicate that the person's problem(s) is/are solved and critical needs are met (e.g., achieved adequate well-being, has essential supports for living, functions adequately in daily activities, and fulfills key life roles)?

Case Formulation Worksheet - Mateo

1. Person's Situation: Mateo is a 35-year-old combat vet living a recovery-oriented HUD apartment. He suffers severe bouts of depression during which he binges on alcohol or cocaine and may become suicidal. Relationship losses, loneliness, flashbacks, and nightmares may trigger bouts of depression. After suffering a major heart attack, he lost his job as a truck driver. He receives SSDI and struggles with limited income. He seeks to restore relationships with estranged family members, wants to father is son of 4 years, seeks part-time employment, and works toward recovery and improved physical health.

Present Vulnerabilities (Predisposing Fa tors)

Present Stressors & Triggers (Precipitating Factors)

Drivers & Sustainers (Perpetuating Factors)

2. Presenting Problem(s):

1) *[Self-Endangerment]*

2) *[Estrangement & Isolation lead to Self-Endangerment]*

3) *[Illness & Wellness]*

4) *[Permanent Housing]*

Major Predictors (Prognostic Factors)

Person's Desired Life Changes:

Severity of Clinically Significant Distress & Impairment in Functioning

To what degree do presenting problems lead to clinically significant distress and impairment (using DSM-5 levels of severity)?

Mild Degree Moderate Degree Severe Degree

3. Solution Possibilities for Positive Life Change, Wellness, and Recovery - For Use in Intervention Planning:

A. Strategies to Prevent Harmful Things that Could Happen Again:

B. Strategies to Meet Any Critical, Un-Met Needs:

C. Strategies to Improve Well-Being and Basic Supports for Living:

D. Strategies to Improve Daily Functioning & Life Role Fulfillment:

Intervention Planning Worksheet

Mateo's Concerns & Aspirations:

Mateo says his wellness and recovery goals are: ***• Getting my health issues under control. • Being clean and staying sober. • Supplementing my current income with paid part-time work. • Fathering my four-year-old son, Pepe, like a real dad. • Building relationships with my older children. • Participating in church activities and continuing his spiritual journey to get to a better place in life. • Getting a bigger apartment so that Pepe can come stay with me on weekends. • Having a stable, healthy relationship with a good woman who doesn't use substances and who likes me for who I am and who I am becoming.***

Presenting Problems & Critical Unmet Needs:

- Mateo's serious and repeated bouts of depression contributed to binging, suicidality, hospitalizations, and past relapses.
- Mateo's broken and lost relationships, remorse, loneliness, and PTSD symptoms trigger bouts of depression and relapses.
- Mateo's homelessness resulted from his depressive bouts, substance use disorder, and hospitalizations. He lives in a transitional apartment today but must have permanent housing within six months.

Risk Factors & Specific Threats to Well-being:

- Mateo is at risk of new bouts of depression that may lead to relapse.
- Loss of a key person in his life is very powerful trigger for relapse.
- Pepe, a powerful motivator for Mateo, may move away within the next month due to his mother changing jobs.
- Mateo must find permanent housing within the next six months.
- Mateo is at risk of another major heart attack yet continues smoking and is having trouble affording/shopping for healthier food and knowing how to prepare it.

Functional Strengths & Assets:

- Mateo has normal intelligence, stable health, many ADL skills, SSDI income, health care, and history of successful employment.
- Mateo is motivated by desires to father his 4-year old son, Pepe.
- Mateo participates in treatment and is medication compliant.
- Mateo participates in AA/NA and is working the 12-Steps.
- Mateo is seeking part-time paid employment.
- Mateo has social supports from a sister, former wife, and church.
- Mateo is motivated to reduce smoking and improve healthful eating.

Outcome & Intervention 1: Mateo "Gets His Health Issues Under Control"

Necessary Life Change: Mateo shops for and prepares healthier meals.

Goal (Action SOC): Mateo gains/uses skills in shopping for and preparing healthier meals.

Objective:

Interventions: CSW and Health Educator help Mateo make healthful choices and behavior changes.

1.

2.

3.

4.

5.

6.

7.

- Attainment will be measured by

Outcome & Intervention 2: Mateo Fills Time to "Be Clean and Stay Sober"

Necessary Life Change: Mateo overcomes idleness, loneliness, and isolation (triggers for relapse).

Goal (Action SOC): Mateo gains purpose in life, fills idle time, and avoids isolation and loneliness (some of his triggers) by serving as a church volunteer for four half-days per week.

Objective:

Interventions: CSW assists Mateo in securing a part-time volunteer job at this church.

1.

2.

3.

4.

5.

6.

- Attainment will be measured by

Reflection & Adjustment Worksheet

Reflect on Emerging Clinical Matters in Recent Encounters and Identify Adjustments that Should Be Made

Working from the Encounter Notes Exemplar, identify any matters of practical or clinical significance that surfaced during recent encounters with Mateo. Reflect on the significance of those matters and then specify updates and adjustments, if any, that should be made to the Case Story, Bio-Psycho-Social Assessment, Clinical Case Formulation, and Outcomes and Interventions stated in Mateo's Treatment Plan. Using the worksheet below, note any adjustments to be made or Next Steps to be taken.

Encounter 1: Mateo "Gets His Health Issues Under Control" (CSW's Reflections)

Note Any Updates & Adjustments to be made in the following items:

• Mateo's Case Situation to be Communicated to Team Members & Providers:

• Mateo's Bio-Psycho-Social Assessment or Any Next Step Probes:

• Mateo's Clinical Case Formulation or Any New Case Understanding:

• Mateo's Outcomes, Goals, or Objectives:

• Mateo's Interventions or Related Courses of Action:

Encounter 2: Mateo Fills Time to "Be Clean and Stay Sober" (CSW's Reflections)

Note Any Updates & Adjustments to be made in the following items:

• Mateo's Case Situation to be Communicated to Team Members & Providers:

• Mateo's Bio-Psycho-Social Assessment or Any Next Step Probes:

• Mateo's Clinical Case Formulation or Any New Case Understanding:

• Mateo's Outcomes, Goals, or Objectives:

• Mateo's Interventions or Related Courses of Action:

Appendix E: Statutes and Regulations

Introduction:

The Licensing Boards provide specific regulations and direction for each discipline. In addition, New Mexico has specific reporting requirements and statutes related to:

The following citations address:

- Children Youth and Families Department
- Human Services Department – Critical Incident Reporting

Adult Protective Services

Children's Protective Services (CYFD)

Critical Incident Reporting (HSD)

New Mexico Licensing Boards

Counseling and Therapy Board

Psychology

Social Work

Appendix F:

State Licensing and Credentialing Boards

Licenses and credentials serve an important public safety function to behavioral health fields. It is important for supervisors to model good habits with licensure to their supervisees, including displaying their license, renewing their license on time, and keeping up with continuing education.

Many behavioral health professions in New Mexico have an independent licensure that providers can gain through a combination of practice experience and supervision. While each individual is responsible for their own supervision process, it is good practice for the supervisor as the senior clinician to consult with the licensing and supervision standards for their various supervisees to avoid providing erroneous information that can delay a supervisee's progression to independent licensure.

The following is a listing of the behavioral health licensing and credentialing boards in the state with a brief overview of the supervision rules specific to these boards, as well as where to find more details, as of June 2018.

- New Mexico Board of Nursing: http://nmbon.sks.com/
    - Supervision is required for some types of nurses, primarily those given a permit-to-practice prior to being fully licensed.
        - RN permit-to-practice: supervision from an RN only. To see the current rules on this, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.10 Licensure Requirements for Registered and Practical Nurses"
        - LPN: all LPNs must receive direct supervision to do any procedures that goes "beyond basic preparation for practical nursing." To see the current rules on this, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.10 Licensure Requirements for Registered and Practical Nurses"
        - GNP permit-to-practice: supervision can be from a physician, CNP, or CNS; direct supervision is specifically required to prescribe. To see the current rules on this, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.13 Advanced Practice Registered Nurse (APRN) Certified Nurse Practitioner (CNP)"

        - GCNS permit-to-practice: supervision can be from a CNS, CNP, or a physician in their specialty; direct supervision is specifically required to prescribe. To see the current rules on this, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.15 Advanced Practice Registered Nurse (APRN) Certified Nurse Specialist (CNS)"
    - For all nurses, supervision can only be done face-to-face and with an appropriate provider who is within the organization at which the supervisee is working. For more details, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.7 Definitions"

- New Mexico Board of Social Work Examiners: http://www.rld.state.nm.us/boards/social_work.aspx
    - To earn an LCSW or LISW, LMSWs are required to complete a certain number of supervision hours and hours in practice (which includes all work and is not limited to client contact hours), with only some of the supervision hours being permissible through group supervision. As of June 2018, this is 90 hours of supervision and 3,600 practice hours, with 20 hours of group supervision permitted. To see the current rules on this, see the website's "Rules and Laws → Chapter 63 Social Workers → 16.63.11 NMAC: Independent Social Worker → 16.63.11.8 Qualification for Licensure"
    - LMSWs can only earn supervision with supervisors approved by the Board of Social Work Examiners. To become an approved supervisor, the clinician must take a supervision class and then submit the certificate along with a form to the board.
        - To find a list of approved classes, see the website's "Forms and Applications → Supervision Classes → Approved Supervision Classes"
        - To apply to become an approved supervisor, see the website's "Forms and Applications → Supervision Forms → Supervision General Directions and Application"
        - Who is an approved supervisor? See the Approved Supervisors List under the website's "Forms and Applications → Supervision Classes → Approved Supervisors List"
    - LMSWs can only receive a limited number of supervision hours from an approved supervisor who is not an LCSW or LISW. As of June 2018, this is 30 hours. To see the current number of permissible hours, see the website's "Rules and Laws → Chapter 63 Social Workers → 16.63.11 NMAC: Independent Social Worker → 16.63.11.8 Qualification for Licensure"

- Telesupervision is permitted for all supervision hours. For more details, see the website's "website's "Rules and Laws → Chapter 63 Social Workers → 16.63.1 NMAC: General Provisions → 16.63.1.7 Definitions"

- New Mexico Counseling and Therapy Practice Board: http://www.rld.state.nm.us/boards/counseling_and_therapy_practice.aspx
  - All counseling licenses require a certain number of supervision hours and client contact hours to be completed. The amount varies by license.
    - LPCC or LPAT: As of June 2018, LMHCs must complete 3000 hours of client contact and 100 hours of supervision, with no limits on individual versus group supervision. Some of these client contact hours can be done in an internship, depending on type of license.
      - LPCC: Up to 1000 client contact hours can be done in an internship. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.4 NMAC: Requirements for Licensure as a Professional Clinical Mental Health Counselor (LPCC) → 16.27.4.11 Documentation Required of Licensure"
      - LPAT: Up to 750 client contact hours can be done in an internship. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.7 NMAC: Requirements for Licensure as a Professional Art Therapist (LPAT) → 16.27.7.10 Applicants for Licensure"
    - LMFT: As of June 2018, LAMFTs must complete 1000 hours of marriage and family client contact and 200 hours of supervision; up to 100 of the supervision hours can be done in group. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.6 NMAC: Requirements for a Marriage and Family Therapist (LMFT) → 16.27.6.9 Applicants for Licensure"
    - LADAC: As of June 2018, LSAAs must complete 1000 hours of client contact and 50 hours of supervision. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.11 NMAC: Requirements for Licensure with Examination as an Alcohol and Drug Abuse Counselor (LADAC) → 16.27.11.9 Applicants for Licensure"
  - All counseling licenses can receive supervision from most types of independently licensed behavioral health providers, with no limits on hours from interdisciplinary supervisors. However, most of the licenses require the supervisor to have specialization in the respective field (e.g. substance use for those seeking LADAC, art therapy for those seeking LPAT, marriage/family

therapy for those seeking LMFT). To see the current rules on this, see the "appropriate supervision" section for each individual license's rules, the directions to which are above.

- There are no limits indicated for any of the counseling licenses regarding supervision to be done by televideo versus face-to-face. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.19 NMAC: Approved Supervisors"

- New Mexico Medical Board: http://www.nmmb.state.nm.us/
  - To become a licensed medical doctor (which includes psychiatrists), a postgraduate trainee must work for at least 3 years and have their work observed directly by at least 2 physicians, chiefs of staff, or department chairs (no specific number of hours indicated) who can recommend them for licensure. To see the current rules on this, see the website's "Rules and Statues -> Governing Statutes and Rules → Physicians: Licensure Requirements → 16.10.2.10 Medical License by Endorsement"

- New Mexico Office of Peer Recovery and Engagement: http://newmexico.networkofcare.org/mh/content.aspx?id=11894
  - Certified Peer Support Workers do not have any specific supervision requirements. Please see their website for more information.

- New Mexico Psychologist Examiners Board: http://www.rld.state.nm.us/boards/Psychologist_Examiners.aspx
  - To become a licensed psychologist, an associate must complete a certain number of hours in practice (some of which need to be client contact hours) while under supervision; pre-doctoral supervised experience can account for some of these hours. As of June 2018, 3000 practice hours are required, with 750 of these hours being client contact hours; up to 1500 hours in an APA-approved pre-doctoral internship or 750 hours in a non-APA-approved pre-doctoral internship can be applied to the total 3000. For see the current rules on this, see the website's "Rules and Laws → Chapter 22 Psychologists and Psychologist Associates → 16.22.6 NMAC: Psychologists – Predoctoral and Postdoctoral Supervised Experience → 16.22.6.8 Supervised Experience Leading Towards Licensure"
  - Psychologist associates can only receive supervision from psychologists. There are no limits on whether this supervision is individual or in a group. For more details on this, see the website's "Rules and Laws → Chapter 22 Psychologists and Psychologist Associates → 16.22.6 NMAC: Psychologists – Predoctoral and

Postdoctoral Supervised Experience → 16.22.6.8 Supervised Experience Leading Towards Licensure"

- Predoctoral supervision can occur with an off-site supervisor with no indicated limits, while a postdoctoral supervision only allows for some telesupervision if the supervisor and supervisee live far apart. As of June 2018, 2 hours of telesupervision per month are allowed if the supervisee and supervisor live more than 100 hours apart. For more details on this, see the website's "Rules and Laws → Chapter 22 Psychologists and Psychologist Associates → 16.22.6 NMAC: Psychologists – Predoctoral and Postdoctoral Supervised Experience → 16.22.6.8 Supervised Experience Leading Towards Licensure & 16.22.6.9 Conditions of Postdoctoral Supervision"
- Postdoctoral supervision requires a documented supervisory plan approved by the board in order for the board to accept the hours. This plan can be done at the end of the supervision time, but is recommended to be submitted prior to or at the beginning of the supervised practice. For details on what this plan should contain, see the website's "Rules and Laws → Chapter 22 Psychologists and Psychologist Associates → 16.22.6 NMAC: Psychologists – Predoctoral and Postdoctoral Supervised Experience → 16.22.6.10 Postdoctoral Supervisory Plan"

Appendix G: Additional References

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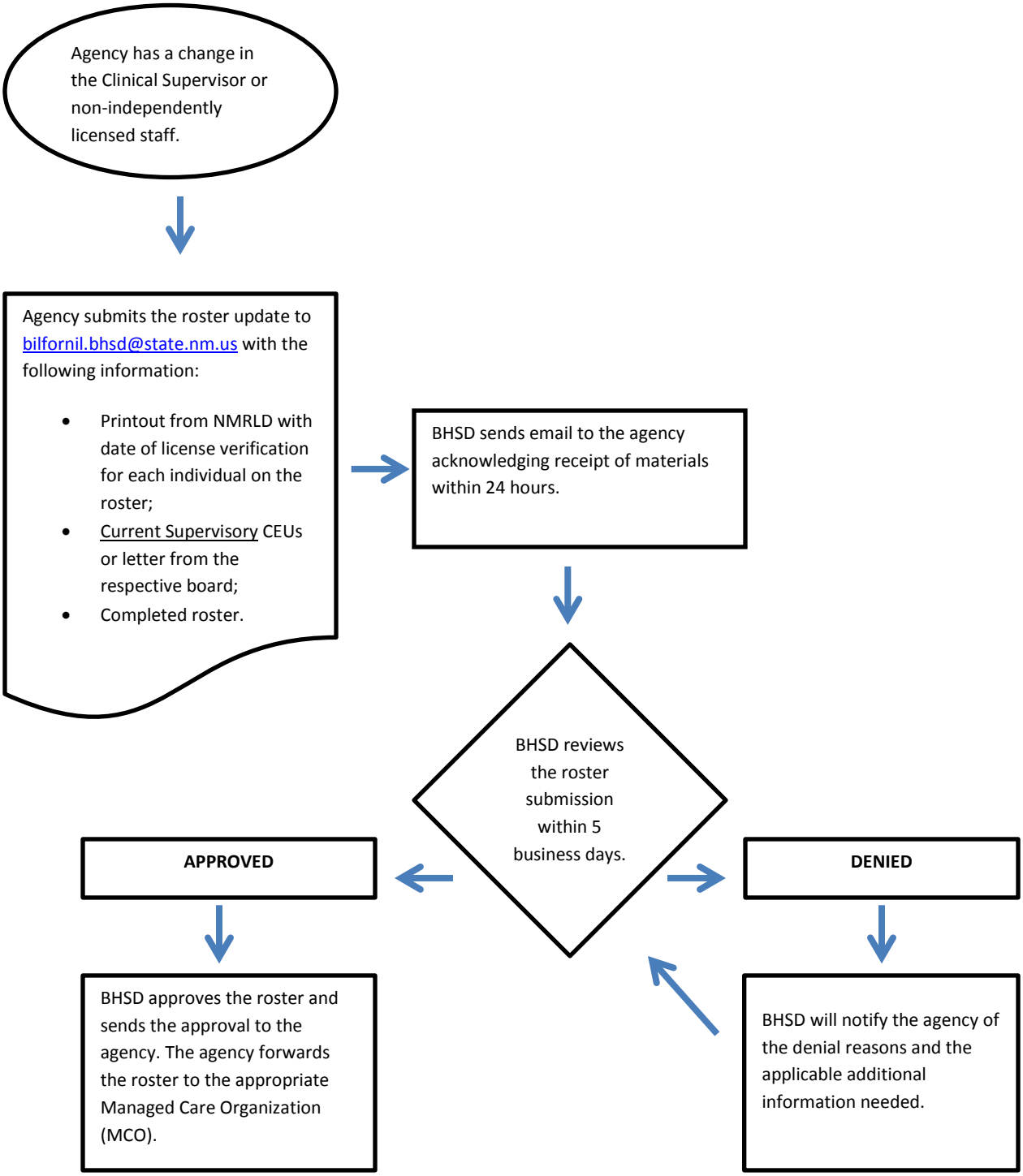
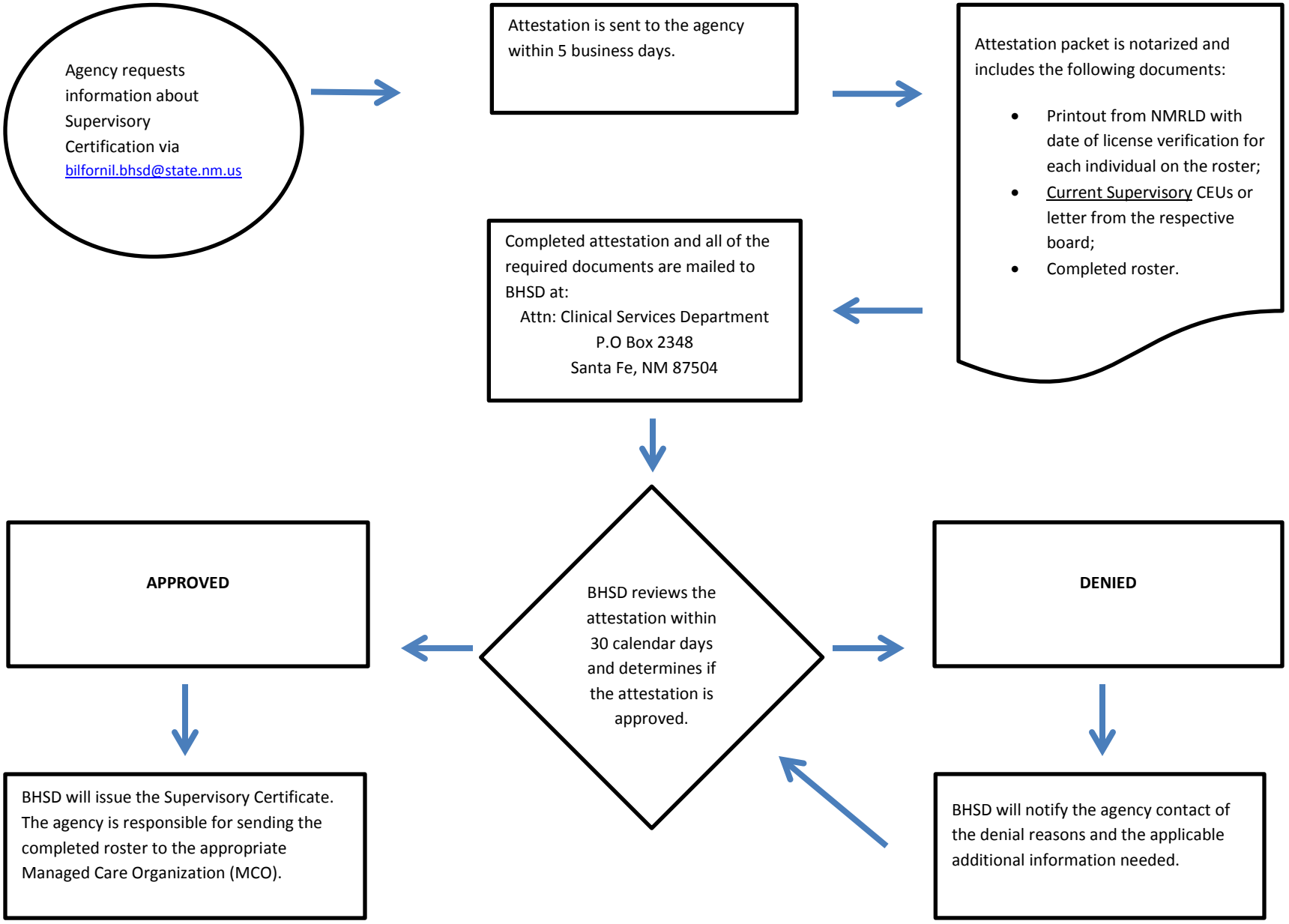
APPENDIX G

Supervisory Certification Process- Roster Updates



APPENDIX H

Supervisory Certification Process



HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary

Wayne W. Lindstrom, PhD., Director, BHSD
CEO, Behavioral Health Collaborative

Supervisory Certification
Certification Attestation Application

Supervisory Certification is a major component of a wider workforce development strategy for the State of New Mexico's Behavioral Health service delivery system. The purpose of this certification process is for Behavioral Health Agencies (BHA 432) and Opioid Treatment Programs (OTP 343) to demonstrate that there is: ongoing education, learning and oversight of clinical supervisors and non-independently licensed (NIL) practitioners. Additionally, this certification is in place to support competent consultation and supervision. It is required in order to be eligible for reimbursement for services from Medicaid delivered by a non-independently licensed provider. Refer to The Behavioral Health Policy and Billing Manual (Clinical Supervision and Supervisory Certification sections) for additional information.

Supervisor
Clinical supervisors must adhere to all state board regulations and maintain active licensure in one of the follow categories: LMFT, LPCC, LCSW/LISW or any professional license recognized by the board as a clinical supervisor.

Supervisee
Those who are under supervision must have completed all necessary requirements for their licensure type. Some agencies and programs may require background checks on persons rendering services. This certification excludes any and all provisionally or temporary licensed individuals. The non-independently licensed provider scope of practice includes the following: rendering social work and/or counseling related services, which may include evaluation, assessment, consultation, diagnosing, development of treatment plans, client-centered advocacy, case management and referral, appraisal, crisis intervention education, reporting and record keeping for individuals, couples, families or groups as defined by rule and New Mexico Statutes: Counselors Scope of Practice 61-9A-5, Social workers Scope of Practice 61-31-6. Additional guidelines or rules may exist by the respective professional licensing board which must be followed.
The attestation includes specific criteria required under the Supervisory Certification policy. Each area is subject to review and should be substantiated by an organization's identified processes as delineated in policy and procedures (P&Ps), employee handbook, and/or training curriculum. The glossary at the end of this application will further define terminology used herein.

In order to demonstrate appropriate licensure and qualifications of both the rendering non-independently licensed provider and the Clinical Supervisor, the below components will need to be available for review by the state, MCO, or third-party payer upon request:

1. Names and supporting documentation of personnel providing Clinical Supervision within the agency and the criteria used for hiring both supervisors and NILs. Supporting documentation must include:

i. Example of hiring criteria or copies of relevant posted positions.

ii. If the agency contracts with its providers a copy of that agreement for each non-independently licensed provider and supervisor.

iii. A copy of the Supervisor's license (must be current for upcoming year).

iv. Proof of Supervisor's attendance for Clinical Supervision training or completed hours as an independently licensed clinician (this should include a copy of board certificate).

v. A copy of Supervisor's resume to demonstrated supervisory experience.

vi. Documentation describing appropriate supervisor to supervisee ratios.

2. Supervision logs that document dates and duration of Clinical Supervision for each non-independently licensed provider staff at the agency for the past 90 days or most recent depending on date of hire or contract.

3. Roster for the non-independently licensed providers who will provide services and their designated Supervisor along with;

- A printout with a date of the license verification from the New Mexico Regulation and Licensing Department (NMRLD) website. We don't require this anymore, however are we still going to require the Master's degree for the LADAC or is this changing? Current CEUs demonstrating that the Clinical Supervisor is approved to provide clinical supervision (LPCC) or the board approval letter (LCSW);**iii.** Demonstrate that the provider (Supervisor and non-independently licensed provider) has an active NPI (National Provider Identifier) number through the National Plan & Provider Enumeration System (NPPES).

4. Demonstrate that appropriate services are provided by the non-independently licensed provider in accordance with Service Definitions, CPT code allowances, agency designated fee schedules and contracts with payers, and the relevant NM Statute Scope of Practice criteria.

Ethical and Legal Obligations

BH Clinical Supervision practices must follow the appropriate guidelines for each licensure type as set forth by the respective New Mexico behavioral health licensing board, NM Statute Scope of Practice, and respective national ethics standards, including the American Psychological Association (APA), American Counseling Association (ACA), and the National Association of Social Workers (NASW).

Scopes of Practice (SOP)

Those who are providing clinical supervision must do so within their scope of practice and level of training and education both in terms of their practice and the practice of those they are supervising. Those who are rendering services must also be practicing within their licensure type's legal scope of practice standards as outlined by the respective board and New Mexico statutes and regulations.

It is the responsibility of an agency to be able to demonstrate that the basic standards of BH Clinical Supervision are met through its policies and procedures. Please review the Clinical Supervision Implementation Guide for additional information.
https://www.nmbhpa.org/clinical-supervision-implementation-guide/

Policies and Procedures Manual

Clinical Supervision is a way to educate and train those coming into the field or provide guidance to those

who are providing services under specific certification or specialized behavioral health service definitions. This includes providing information on appropriate clinical practice as well as system components that influence billing and reimbursement practices. There are clinical supervision documents that have been developed by the clinical supervision workgroup. For more information on these documents contact Betty Downes at Betty.Downes@state.nm.us.

Clinical Supervision programs must include the below components in a policy and procedures manual. The components must clearly articulate how Clinical Supervision practices are operationalized on a day-to-day basis. Ethical codes of conduct must be incorporated in accordance with relevant guidelines by APA, ACA, and the NASW. Standards of BH Clinical Supervision practices, whether employed or contracted, should address the areas noted below and be available for review:

a. Informed consent and disclosure guidelines.
b. Consumer safety.
c. Privacy and confidentiality.
d. Record keeping and fees.
e. Clinical roles and relationships, including patient-therapist relationships and boundaries.
f. Professional growth and development planning.
g. Professional competence: training, cultural awareness in practice, self-care, consultation.
h. Treatment safety and transition planning: termination and referral, end of life care, advanced directives or psychiatric advanced directives (PAD), crisis and safety planning, care coordination, continuity of care.
i. Assessment and trauma informed clinical practice.
j. Ethical and legal issues.
k. Critical incident reporting.
l. A section on State and other relevant resources for attending to crisis situations including: New Mexico Crisis and Access Line information, Suicide hotlines, and how to call and utilize local Crisis Intervention Team (CIT) services as well as what the agency's procedures are in the event of an emergency.
m. Population specific: Any provider organization service array applicable training and/or certification requirements/guidelines including child development, trauma informed care, family support, peer recovery, domestic violence, sexual assault, assessments and screening.

Once the agency has presented the Supervisory Certification letter from BHSD to Conduent and the relevant MCOs, and the rostering has been completed, they may utilize the non-independently licensed provider's name and NPI in the rendering field on the claim.

Medicaid ID and NPI

All providers who will be rendering services for Medicaid eligible recipients must have acquired their own Medicaid ID through the Conduent/MAD enrollment process. An individual must have an active NPI (*National Provider Identifier*) number through the *National Plan & Provider Enumeration System* (NPPES). This is required for all providers independent of the agency NPI. All providers must be registered for their own individual Medicaid ID number using their individual NPI.

Credentialing

In accordance with roster practices, all agencies who qualify and that are designated to bill for non-independently licensed provider rendered services must maintain an up-to-date BH Clinical Supervision and non-independently licensed provider roster. Any changes in status of a non-independently licensed provider or respective Supervisor must be reported within seven (7) days as outlined by either the relevant state

agency, the MCO's, and third-party payers as appropriate. Credentialing of licensed practitioners is generally done through CAQH (Council for Affordable Quality Healthcare) but other requirements may be in place depending on a provider's credentials and licensure type. Each MCO or third-party payer will be able to provide their specific requirements.

Change in Agency Address and New Locations

If the agency is changing the location of their practice, the address needs to first be updated with Conduent. Once the change has been accepted, the agency is responsible for notifying BHSD so that a certification letter with the new address can be issued. The agency must also notify BHSD of any policy and procedure changes for the new address. If the agency desires to open a new location, the agency will need to complete the enrollment process with Conduent, as well as submit a separate attestation for that location. Upon approval of the enrollment and attestation, the agency will receive an additional certification letter for the new location.

Documentation Requests and Site Visits

The Human Services Department (HSD) or any of its designated payers may request the agency's policies and procedures pertaining to the Supervisory Certification Protocol at any time. These documents must be made available upon request. HSD/BHSD may conduct site visits, and will notify the agency in advance to schedule a visit before arriving on site.

Instructions:

The Supervisory Certification Attestation shall be completed by both the Executive Director/Chief Executive Officer, and the Clinical Director signed by both parties and notarized by a certified Notary.

Each area is subject to review and should be substantiated by an organization's identified processes as delineated in policy and procedures (P&Ps), employee handbook, and/or training curriculum.

In order for the Supervisor Protocol Attestation to be complete you will to ensure the following:

- Supervisory Certification policies and procedures are in place for the agency;
- Supervisory Certification Attestation is signed by the Executive Director/Chief Executive Officer, and the Notary;
- The roster is complete with the requested information for both the Clinical Supervisor and the non-independently licensed provider;
- the current CEUs
  demonstrating that the Clinical Supervisor is approved to provide clinical supervision (LPCC) or the board approval letter (LCSW);
- BHA 432 or 343 status from Medicaid stating that the agency is certified as as either one of these provider types.
- Printout with the date from the NMRLD showing the current status of licenses for all providers listed on the roster.

When the Supervisory Certification Attestation is complete, the agency shall retain a notarized copy of the attestation and send the original to:

Behavioral Health Services Division
Attn: Clinical Services
PO Box 2348
Santa Fe, NM 87504

Upon receipt of the attestation, the Clinical Services Team (CST) will have 30 business days to review the information. Based on the review, the CST can approve the attestation or request additional information. If additional information is requested, agencies will have 45 business days to respond from the date of the request. If no response is received, the original attestation request will be considered void. An agency can submit a new attestation at any time.

Once the attestation is approved, a letter of certification will be issued by BHSD to the approved provider type, identified in the Behavioral Health rule. It is the responsibility of the provider organization to notify the MCO(s) with which they are contracted, of the certification status and provide a copy of that letter.

It is the provider agency's responsibility to update the roster each time there is a new non-independently licensed provider or change in clinical supervisor. **All pertinent information will also need to be submitted with the roster.** Updated rosters and any questions pertaining to this process shall be sent to: bilfornil.bhsd@state.nm.us.

Supervisory Certification Attestation

Be sure to follow all of the application's instructions and provide the section and page number that demonstrates compliance with each criteria that can be found in your policies and procedures, handbooks, and/or training manual .

Organization / Agency Information

Agency/Provider Organization: _____

Administrative Office Address: _____

Main Contact/Clinical Director or CEO: _____

Email: _____ Phone: _____

Agency Medicaid Enrollment ID: _____

Agency NPI: _____

I have read and understand pages one (1) through seven (7) of this packet.
_____ Clinical Director/Supervisor Initial here
_____ Executive Director/ CEO Initial here

I _____, the Executive Director or Chief Executive Officer
(circle one) of _____ attest to the following:
Agency Name

1. This agency provides the following services (age of clients, type of interventions, specialty populations, specialty interventions, etc.). If you have identified a specialty please describe additional training and/or certification attained in accordance with state or national requirements/guidelines (If you need additional space please feel free to attach information to the application.)

_____
_____
_____
_____
_____
_____

2. **The agency has policies and procedures** with detailed descriptions of processes for verifying and tracking appropriate level licensures noted for each of the Clinical Supervisors and non-independently licensed providers.

These policies and procedures include time frames for: verifying licenses and any violations on the Licensing Registry, CEU requirements for supervision, renewal dates, whether or not the licensee is a recognized supervisor by their board.

These policies and procedure state that the following are acceptable non-independent licenses (Master's level or above required): Licensed Mental Health Counselor (LMHC, provider type 445, specialty 122), Licensed Master's Social Worker (LMSW, provider type 445, specialty 087) Licensed Associate Marriage and Family Therapist (LAMFT provider type 445, specialty 058) and Licensed Alcohol & Drug Abuse Counselor (LADAC, provider type 440, specialty 124).

These policies and procedures state that the following are allowable services within the provider's scope of practice:
- 90791
- 90846, 90847, 90849, 90853 – family and group psychotherapy

_____ Initial here

3. **The agency has policy and procedure** that states that the following are acceptable independent licenses for the role of clinical supervisor (Master's level or higher required), as identified by the State of New Mexico and/or the NM RLD.

_____ Initial here

4. **The agency has policy and procedure** that addresses record keeping processes for employee and contractor files. This policy and procedure include a description of the contents and maintenance of records, background checks, qualifications, transcripts, licensure, job description, written contract, and all training and orientations attended.

_____ Initial here

5. **The agency has policy and procedure** that describes the agency's understanding of ensuring clinicians have the

following with expected time frames for completion (i.e. at hire, within 30 days, within 90 days, etc.):

- CAQH
- NPI per the NPPES
- Medicaid provider status
- Rostering with MCO's

_____ Initial here

6. **The agency has policy and procedure** that ensures the following documentation is on record:

- Copy of all clinical licenses (independent and non-independent)
- Proof of clinical supervisor status from the appropriate board and accompanying Continuing Education Units (CEUs).
- Liability insurance for non-independent providers and supervisors.
- Job Description for non-independent providers (include qualifications and outline of employment responsibilities)
- Job Description for supervisors (include qualifications and responsibilities of licensed clinicians to include supervisory duties and scope of services rendered)
- Contract or employment agreement.
- Supervision documentation or log for non-independent providers.
- Supervision and consultation documentation for independently licensed providers.
- Quality Service Review or similar reflective improvement practice.

_____ Initial here

7. **The agency has policy and procedure** that describes in detail the orientation process for new employees to ensure that providers have working knowledge of the agency's

August 2018 Supervisory Certification 10

practices and operations. These policies and procedures include an employee handbook (if applicable), and/or other relevant materials. These policies and procedures are reviewed annually.

_____ Initial here

8. The **agency has policy and procedure** that describes appropriate accommodations and rooms for supervision, monitoring, and maintaining consumer confidentiality.

_____ Initial here

10. **The agency has policy and procedure** that describes in detail expected provider response to any safety issues.

_____ Initial here

11. **The agency has practices that** demonstrate that the environment supports trauma informed care (i.e. lighting, client and staff safety, and accessibility to include ADA accommodations).

_____ Initial here

CLINICAL PRACTICE/TRAINING

I _____ as the Clinical Director or Clinical Supervisor (circle one) for _____ attest to the following:

Agency Name

1. **The agency has policy and procedure that** describes the process by which the appropriate clinical supervision will be provided and documented. These policies and procedures will describe in detail guidelines specified per applicable licensing board or regulatory entity. These policies and procedures will include descriptions of frequency, duration, group supervision (number of participants/supervisees allowed), and individual supervision to be provided.

_____ Initial

2. **The agency has policy and procedure that** describes the ongoing education and training of non-independently licensed providers. These policies and procedures include the following required training/education to be provided to non-independently licensed providers and supervisors:

• Treatment planning (intake to discharge)

Crisis planning with consumers

• Documentation (requirements)
• Clinical reasoning/case formulation
• Clinical practice (roles and responsibilities)
• Cultural awareness
• Trauma informed care
• Critical incident reporting/ abuse, neglect and exploitation
• Resource information and referral
• Crisis management/local, state and national help/hotlines, county emergency plans and procedures
• Boundaries with clients
• Code of ethics as applicable from associations APA, ACA, or, NASW, state regulations, and national standards
• Continuum of care (Termination of Care, Referral, End of life Care, advance directives, psychiatric advance directives)
• Rendering services in alignment with applicable state laws and regulations (Medicaid and non-Medicaid funds), documentation requirements, service definitions, and CPT code allowances
• Self-care
• Informed Consent and Disclosure of protected information guidelines
• Maintaining privacy/confidentiality
• Client Records (securing client information-record keeping)

_____ Initial here

3. **The agency has policy and procedure that** ensures ongoing professional development, supervision and/ or professional consultation for the clinical supervisor. The policy and procedure includes risk management, ethics, and legal implications of supervision, supervision theory, training in areas of agency specialty, remediation, and documentation.

_____ Initial here

4. **The agency has policy and procedure that** describes the agencies supervision model and philosophy. This policy and procedure includes ratio of non-independently licensed providers to clinical supervisors.

_____ Initial here

5. **The agency has policy and procedure that** describes what a supervision agreement is and why it is used between the clinical supervisor and the non-independently licensed provider. The policy and procedure describes in detail when the supervision agreement is reviewed initially and ongoing. These policies and procedures outline the rights and responsibilities of the supervisor and supervisee.

_____ Initial here

6. **The agency has policy and procedure that describes** supervision documentation to include logs for non-independent providers.

_____ Initial here

7. **The agency has policy and procedure that describes** supervision and consultation documentation for independently licensed providers.

_____ Initial here

ADMINISTRATIVE & CLINICAL

1. **The agency has policy and procedure that** describes the ongoing evaluation of non-independent providers and supervisors. The policy and procedure includes timeframes for evaluation and creation of a professional development plan. These policy and procedure describes how non-independent providers and supervisors demonstrate competency.

_____ Clinical Initial here _____ Executive Director/ CEO Initial here

2. **The agency has policy and procedure that** describes the process for addressing grievances and complaints about providers.

_____ Clinical Initial here _____ Executive Director/ CEO Initial here

3. **The agency has policy and procedure that** describes how the agency supports reflective practice.

_____ Clinical Initial here _____ Executive Director/ CEO Initial here

AFFIDAVIT AND NOTARIZATION The undersigned, being duly sworn, upon his/her oath deposes and says that he/she is the person making the foregoing statements and that they are made in good faith and are true in every respect. By executing this application, the undersigned also acknowledges that he/she has read the requirements for the Supervisory Certification and, if issued a certificate, agrees to conform with and support the development of non-independently licensed providers and ensure that non-independently licensed providers are receiving adequate supervision and operating within their scope of practice outlined in the supervisory certification. I certify that all of the statements made in this application are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

_____ _____

Signature of Applicant Date

August 2018 Supervisory Certification 13

STATE OF _____

COUNTY OF _____

BEFORE ME on this _____day of this_____ month, 20_____

personally appeared the above named applicant who, being by me duly sworn upon oath, states that all statements and answers contained in this application are true and correct.

_____

Notary Public

SEAL

_____

My Commission Expires

Approved by HSD

_____ _____

Clinical Services Representative Date

The following individuals named on this roster are approved by BHSD under the Supervisory Certification Clinical Supervision policy.
All clinicians listed must at a minimum have a Master's degree. Temporary and provisional licensees do not qualify.

Provider Name (Supervisor)	Licensure Type	License #	Effective & Expiration date	Individual NPI #	Date of Birth	Individual Medicaid ID #	Clinical Supervisor listed with board? Y/N
Provider Name (NIL)	**Licensure Type**	**License #**	**Effective & Expiration date**	**Individual NPI #**	**Date of Birth**	**Individual Medicaid ID #**	**Supervisor Name/ Licensure Type**

Attestation

I certify that the responses in this attestation and certification application, including referenced information in the document, are accurate, complete, and current as of this date. I and my agency providers have read and understand the BIL4NILs Clinical Supervision Policy, state regulations and statutes relative to rendering and seeking reimbursement for services through the Human Services Department and Behavioral Health Services Division of the State of New Mexico. All supervisors have been trained to provide appropriate clinical supervision on the above listed items and read and understand our agency Policies and Procedures. All providers practicing in the above noted agency are in compliance with the applicable state board licensing regulations according to their licensure.

Rosters and relative attestation must be updated if there is a change in staffing. Updates must occur both with the BHSD and the MCO's with which an agency is contracted according to each MCO's policies and procedures. RETURN FORM and any applicable P&P to: **bilfornil.bhsd@state.nm.us**

Agency Name and NPI	Print Agency Director/CEO
Signature Agency Director/CEO	Date

Approved by HSD

Clinical Services Team	Date

Glossary of Terms

Agency – the organization that is licensed as a BHA - 432 or OTP - 343.

BH – Behavioral Health.

BHA-432 – Behavioral Health Agency-432 as defined by the Medical Assistance Division (MAD) Behavioral Health Provider Type list. The number designation is a part of a provider type classification system that is utilized by MAD for Medicaid enrollment with Xerox.

BHSD – Behavioral Health Services Division. A division of the State of New Mexico Human Services Department (HSD) overseeing BH providers in the state primarily for adult prevention, treatment, and recovery programs and services.

BIL4NILs – Billing for non-independently licensed practitioners.

CAQH – Council for Affordable Quality Healthcare.

Clinical Supervisor – Independently licensed practitioner or clinician. The reference in this document is specific to clinicians who have acquired a valid license to practice and oversee those who are NILs in the field of Behavioral Health by a State of New Mexico official licensing board as outlined by New Mexico Statutes and Scope of Practice and other specific Rules and Laws of the respective board.

Facility – Used interchangeably with Agency or Organization in reference to the physical location of that entity.

LOD – Letter of Direction. These are letters from the State to MCO's or other entities giving instruction on allowances or
restrictions in terms of practice and delivery of services within their provider networks or internal practices.

MCO – Managed Care Organization. In the case of BH providers and services, the MCO contracts with the HSD to reimburse for services rendered under Medicaid.

NIL – Non-independently licensed practitioner or clinician. The reference to NILs in this document and BIL4NILs are clinicians who have acquired a valid license to practice in the field of Behavioral Health by a State of New Mexico official licensing board as outlined by New Mexico Statutes and Scope of Practice.

NPI and NPPES – National Provider Identifier and National Plan and Provider Enumeration System.

P&P – Policies and Procedures. As referenced in this document can include the agency policies and procedures, the training curriculum relative to staff orientation, or employee handbook.

Practitioner / Clinician – State of New Mexico boards licensed clinician able to render services under Medicaid or other state funds for specific services within Behavioral Health according to New Mexico state Statute and Licensing board regulations Scope of Practice.

Provider – This term is used interchangeably to refer to an organization/agency or the individual practitioner.

Rule or Regulation – New Mexico State or Federally applicable legal Statutes, Administrative Codes, including State Departmental Policies and Procedures for licensing or certification purposes.

SOW/SOP– Scope of Work or Scope of Practice.

Supplement – A Supplement is an add-on of information or a directive to a contract obligation between a state entity and for example the MCOs.

BIL4NILs Clinical Supervision Oversight

RESOURCES AND INFORMATION

For NM Behavioral Health (BH) Providers

State of New Mexico Behavioral Health Services Site – Network of Care
http://newmexico.networkofcare.org/mh/

Featuring:
State-wide services and provider directory with interactive map
(It is important for all providers to ensure that their information is entered and updated as appropriate)

New Mexico Behavioral Health Collaborative information
New Mexico Prevention
Consumer and Family Services
BH Provider Guide for Clinical Practice in NM – (*currently under construction*)

For veterans:
http://newmexico.networkofcare.org/Veterans/

Behavioral Health Provider Association of New Mexico (BHPA)
The provider's voice and attendance at regular meetings with the NM HSD/BHSD to discuss system relevant topics and updates. To inquire about membership please contact: Behavioral Health Providers Association of NM, RE: Membership, 2400 Wellesley Drive, NE., Albuquerque, NM 87107

New Mexico Crisis and Access Line / Peer Warm-line
http://www.nmcrisisline.com/
There may be applications available for agencies for after-hours-coverage. For information contact bilfornil.bhsd@state.nm.us

Human Services Department Provider Information
http://www.hsd.state.nm.us/providers/Default.aspx

Medical Assistance Division (MAD)
http://www.hsd.state.nm.us/Medical_Assistance_Division.aspx

Trauma Informed Care and Organizational Assessments
http://www.bhc.state.nm.us/BHTools/Trauma%20Informed%20Care.html

Care Coordination
Care Coordination is a contracted service through the MCO's. Please contact your MCO's for more information on how this service can assist in helping your clients navigate appropriate services.

BECOMING A BH PUBLIC SYSTEM PROVIDER IN NEW MEXICO

Overview of basic steps for an individual:

1. Completion of required training or a degree to acquire a license to practice within the field of Behavioral Health through one of the State of New Mexico Licensing Boards as outlined by New Mexico Statute for Scope of Practice. This can include acquiring certification to provide services within a specific type of facility/organization for a specific service as outlined in State Medicaid Regulations or other State Department specific rules.
2. Acquire an NPI number.
3. Acquire a Medicaid Enrollment ID number.
4. Register and credential with CAQH.
5. Roster with your agency's contracted MCO(s).

1. Licensing and Certification Boards

Licensure Boards

New Mexico Medical Board http://www.nmmb.state.nm.us/

Board of Psychologist Examiners http://www.rld.state.nm.us/boards/psychologist_examiners.aspx

Counseling and Therapy Practice Board http://www.rld.state.nm.us/boards/counseling_and_therapy_practice.aspx

Social Work Examiners Board http://www.rld.state.nm.us/boards/social_work.aspx

New Mexico Board of Nursing http://nmbon.sks.com/

Certification Boards and Para-Professionals
New Mexico Credentialing Board for New Mexico Professionals http://www.nmcbbhp.org/

Office of Community Health Workers http://nmhealth.org/about/phd/hsb/ochw/

2. National Provider Identifier (NPI) by NPPES

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers and

health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The *Centers for Medicare & Medicaid Services (CMS)* has developed the *National Plan and Provider Enumeration System (NPPES)* to assign these unique identifiers. The website for NPPES is: https://nppes.cms.hhs.gov/NPPES/Welcome.do

3. Medicaid Enrollment ID

The process of acquiring a State of New Mexico provider Medicaid ID is done through the Medical Assistance Division (MAD) Medicaid Portal (Xerox). If the application is completed with all the required information, the process should take no more than 7-10 business days.
Website: https://nmmedicaid.acs-inc.com/static/index.htm

4. Provider Credentialing with CAQH

Provider credentialing is a process that is done through the CAQH Universal Provider Datasource (CAQH ProView – developed by the Council for Affordable Quality Healthcare). This is a combined effort and requirement between the MCOs and CAQH. All MCO's will require credentialing. Their process can take upwards of 45 days provided that the credentialing information is complete.

Website: http://www.caqh.org/solutions/caqh-proview-faqs
Provider assistance: Email providerhelp@proview.caqh.org or call: 888-599-1771.
Registration: https://proview.caqh.org/PR/Registration

Completing the online form requires five steps:

1. Register with CAQH ProView.
2. Complete the online application and review the data.
3. Authorize access to the information.
4. Verify the data and/or attest to it.
5. Upload and submit supporting documents.

The provider data profile created in CAQH ProView meet the NCQA requirements for credentialing application content in CR3, Element C.NCQA reviews CAQH ProView output against the appropriate elements.

5. Rostering with MCOs

The MCO's each have a provider network manual or handbook that should be consulted as to the appropriate path to rostering providers within an organization. Generally this is done through the CEO or assigned administrative personnel between an agency and the contracted MCO. All MCO's have a common form to roster clinicians who are credentialed to render services under public funds.

NM BH LICENSING STATUTES AND REGULATIONS

Provider licensing by primary boards for NILs
Licensures for behavioral health practitioners are issued by different boards depending on the education and training of the practitioner. Each board has its own regulations starting with New Mexico Statutes Annotated (NMSAs) and more specific New Mexico Administrative Codes (NMACs). These include licensure requirements, approved supervisors, and CEU and renewal criteria.

In general, statutes can be searched and reviewed at:

http://www.nmonesource.com/nmnxtadmin/nmpublic.aspx

New Mexico Compilation Commission

Specific rules (NMACs) for licensure requirements and Scopes of Practice, as outlined by Statutes, can be found at the individual Board site pages for Rules and Laws either by clicking on their links for the NM Compilation Commission logo (displayed above) or the icons noted below.

NM Board of Social Work Examiners

Website: http://www.rld.state.nm.us/boards/Social_Work_Rules_and_Laws.aspx
Statute and Scope of Practice for Social Workers: Chapter 61 Occupational and Professional Licensing > Article 31 Social Work Practice

Counseling and Therapy Practice Board

http://www.rld.state.nm.us/boards/Counseling_and_Therapy_Practice_Rules_and_Laws.aspx
Statute and Scope of Practice for Counselors: Article 9A Counseling and Therapy, 61-9A-1 through 61-9A-30

NM SERVICE DELIVERY RESOURCES AND POLICIES

Rendering services and seeking reimbursement within Medicaid or other state funds has several requirements. Be sure to be familiar with each of them including the policies of the Managed Care Organizations (MCOs) that your agency contracts with. Each MCO has their own provider manual that you will want to be familiar with. Some NMACs below may not apply to all providers or all services. If you have questions, be sure to contact our clinical team, your MCO, or the Medical Assistance Division (MAD).

New Mexico Administrative Codes (NMAC) Search Engine:
http://164.64.110.239/nmac/cgi-bin/hse/homepagesearchengine.exe

Access and Links to All HSD Program Rules by Categories:
http://www.hsd.state.nm.us/providers/rules-nm-administrative-code.aspx

Billing for Medicaid services.

- 8.302.1 NMAC – Social Services, General Provider Policies
  - Eligible providers
  - Provider responsibilities and requirements
  - Eligible Medicaid recipients
  - Nondiscrimination
  - Record keeping and documentation requirements
  - Patient confidentiality
  - Provider disclosure
  - Termination of provider status

- 8.302.2 NMAC – Social Services, Billing for Medicaid Services
  - Claims limitations
  - Dual-eligible recipients (Medicare/Medicaid)
  - CPT/HCPCS service unit time frames
  - Co-payments
  - Timely filing

- 8.310.2 NMAC – Social Services, Health Care Professional Services, General Benefit Description

- 8.321.2 NMAC – Social Services, Specialized Behavioral Health Services, Specialized Behavioral Health Provider Enrollment and Reimbursement

Medicare/Medicaid

There are special regulations governing those who are Medicare eligible and/or dual eligible. While some provider licensure types may not be eligible to provide services under Medicare, it is important not to turn away clients before fully understanding the process for coverage and eligibility within both Medicare and Medicaid. Be sure to contact your contracted MCO and review all applicable regulations at the main HDS website in the "Provider" section, including the following rules for direction:

Medicaid's relationship to Medicare – 8.310.2.10 NMAC
Dual eligibility - 8.302.2.12 NMAC

Additional rules that apply to some services and providers

7.20.2 NMAC – Health, Mental Health, Comprehensive Behavioral Health Standards
7.21.1 NMAC – Health, Behavioral Health, General Provisions
7.32.2 NMAC – Health, Alcohol and Drug Abuse, Admission Criteria for Alcohol Substance Service

Level of Care Guidelines (LOCG) and Prior Authorization
Be sure to contact your MCO as to the appropriate forms and processes for both LOCG and Prior Authorization services, including treatment plans and specialty services.

Complete sets of rules under the Human Services Department can be found at:
http://www.hsd.state.nm.us/providers/rules-nm-administrative-code-.aspx

Services and Definitions
http://www.bhc.state.nm.us/BHServices/ServiceDefinition.html

Critical Incident Reporting
It is important to work with your contracted MCO's, Optum Health NM, and/or Xerox as appropriate on reporting critical incidents. Each New Mexico State Department may have its own reporting protocols. Anyone billing Medicaid, state, or other federal funds received through the state must report critical incidents. There is a HSD/BHSD state issued BH CIR Protocol issued as of 2015 that all payors have been provided, that protocol is downloadable from the HSD Portal which is an online entry system that requires login. Please use the email address at the portal to request further information about using the portal. The CIR portal can be found at:
https://criticalincident.hsd.state.nm.us/Login.aspx?ReturnUrl=%2f

Technical Assistance
You may request Technical Assistance (TA) from either the MCO's or the State Department from which you are seeking reimbursement to help inform your practice and to understand how the rules above apply and/or should be operationalized.

Email: **bilfronil.bhsd@state.nm.us** for information on TA for behavioral health related service and program delivery or provider allowances.

IMPORTANT NATIONAL RESOURCES AND POLICIES

CARF – Commission on Accreditation of Rehabilitation Facilities. Website: http://www.carf.org/home/

CMS – Center for Medicare and Medicaid Survey and Certification Compliance. Website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/index.html?redirect=/certificationandcomplianc/02_ascs.asp

COA – Council on Accreditation. An international, independent, nonprofict, human service accrediting organization. Website: http://coanet.org/home/

GPO eCFR – U.S. Government Publishing Office for Electronic Code of Federal Regulation. Website: http://www.ecfr.gov/cgi-bin/ECFR?page=browse

Medicaid – Federal Policy Guidelines.
Website: http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html

Medicare – Information.
Website: https://www.medicare.gov/

NCQA – National Committee for Quality Assurance sets standards and performance measures for providers and health plan organizations to follow. Website: http://www.ncqa.org/

NASADAD NTN – National Association of State Alcohol and Drug Abuse Directors, National Treatment Network. Website: http://nasadad.org/NTN/

NREPP – National Registry of Evidence-based Programs and Practices. Website: http://www.nrepp.samhsa.gov/

SAMHSA – Substance Abuse and Mental Health Services Administration. Website: http://www.samhsa.gov/

The Joint Commission – Accredits provider agencies of programs/services for persons with intellectual and developmental disabilities, including mental health and chemical dependency services. Today, The Joint Commission accredits more than 2,100 behavioral health care organizations under the Comprehensive Accreditation Manual for Behavioral Health Care.
Website: http://www.jointcommission.org/facts_about_behavioral_health_care_accreditation/

The National Council for Behavioral Health – The National Council coordinates the Mental Health First Aid program across the U.S and operates the SAMHSA-HRSA Center for Integrated Health Solutions to provide nationwide technical assistance on integrating primary and behavioral healthcare. We offer
the annual National Council Conference featuring the best in leadership, organizational development, and excellence in mental health and addictions practice.
Website: https://www.thenationalcouncil.org/

National BH Provider Associations

American Psychiatric Association http://www.psychiatry.org/

American Psychiatric Nurses Association http://www.apna.org

American Psychological Association http://apa.org/

American Counseling Association https://www.counseling.org/

National Association of Social Workers https://www.socialworkers.org/

National Association of Addiction Professionals http://www.naadac.org/NCPRSS

APPENDIX J

Centennial Care Behavioral Health Critical Incident Report Form - Updated December 2017

Centennial Care Behavioral Health Critical Incident Report Form

You must report an incident within 24 hours of becoming aware of it.
In the event that an incident occurs on a weekend or holiday, report the incident next business day.

In addition to notifying the MCO, providers must report Abuse, Neglect and Exploitation to:

Adult Protective Service (APS): Telephone: (866) 654-3219 Fax: (505) 476-4913

Child Protective Service (CPS): Telephone: (855) 333-7233 Fax: (505) 841-6691

BHSD Fax: 505-476-9272

Member Centennial Care Category of Eligibility #: ☐

The HSD web portal accepts COEs
001, 003, 004, 081, 083, 084, 090, 091, 092, 093, 094, 95, 100w/NFLOC 200w/NFLOC

Be sure that clinical notes are clear and adequate, do not use acronyms if at all avoidable, and diagnoses should contain a valid code and definition from the current DSM as relevant.

Consumer Demographic Information					
Last Name:		DOB:		Phone Number:	
First Name:		SSN:		Cell Number:	
Initial:		Gender:			
Address:					
City:		State:		Zip Code:	

Clinical Information/Diagnosis

BH Treatment Setting/ LOC and as identified in 8.321.2 NMAC SPECIALIZED BEHAVIORAL HEALTH SERVICES. Check all that are applicable:

☐ ACT	☐ Acute Inpatient Hospitalization		☐ ARTC	☐ BHA	☐ BMS
☐ CCSS	☐ CMHC	☐ CSA	☐ Day Treatment	☐ Detox (Excluding Medical Detox)	
☐ Group Home	☐ IHS	☐ IOP	☐ MST	☐ OTP	☐ PSR
☐ RTC	☐ Rural Health Center		☐ TFC-I	☐ TFC-II	☐ TLS

Other Certified Service (specify):	Other Outpatient (specify):

Incident Information

Date of Incident:		Time of Incident:		Transportation required:	
Date provider first aware of incident:		Date reported to APS:		Date reported to CPS:	
Incident Location:		Other ("Incident Location" field):			
Provided By:		Other ("Provided By" field):			

Type of Incident

- ☐ Severe Harm
  - ☐ Permanent Harm
  - ☐ Severe Temporary Harm
  - ☐ Consumer towards other, not involving law enforcement
- ☐ Missing Recipients
  - ☐ Abduction of any individual served receiving care, treatment, or services.
  - ☐ Elopement from a staffed around the clock care setting (including the ED) leading to death or severe harm.
- ☐ Sexual Incidents
  - ☐ Sexual abuse/assault (including rape) - non consensual sexual contact involving a consumer and another consumer, staff member, or other perpetrator while being treated or on the premises of the organization.
  - ☐ Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization.
  - ☐ Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any individual served receiving care, treatment, or services wile receiving services at the organization.
- ☐ Flame or unanticipated smoke, heat or flashes occurring during an episode of patient care.
- ☐ Death
  - ☐ Unknown requiring follow up with Office of Medical Examiner
  - ☐ Suicide
  - ☐ Medication/treatment error
  - ☐ Natural causes
  - ☐ Accident
  - ☐ Secondary to use of restraints
  - ☐ Member Death by Homicide

Incident Description:

Follow up and Disposition of the Incident:

Actions to Reduce the Re-Occurrence:

Funding Source:			
☐ Medicaid	☐ FFS	☐ CYFD	☐ BHSD
Reporting Agency Name:			
Address:			
City:	State:	Zip Code:	
Agency Phone Number:	Date Submitted:	Insert fax number you have sent form to:	
Reporting individual name:	Reporting individual title:		

HUMAN SERVICES
DEPARTMENT

State of New Mexico
Human Services Department

Behavioral Health Provider
Critical Incident Reporting Protocol

A Collaborative effort of the New Mexico Human Services Department, Children Youth and Family Department, the Centennial Care Managed Care Organizations and the New Mexico Behavioral Health Provider Association.
April 2018

Table of Contents

INTRODUCTION

This document is a product of a collaborative effort among the Human Services Department (HSD), Behavioral Health Services Division (BHSD), the Children, Youth and Families Department, Children's Behavioral Health Division, Managed Care Organizations (MCOs), and The New Mexico Behavioral Health Provider Association. The goal in developing this document is to develop a one-stop reference guide for behavioral health providers who are required to report incidents.

This document is to assist providers in filing critical incidents for those members whose category of eligibility falls outside of the fourteen categories that are reported on the HSD portal.

This document should be considered a summary and supplement to already existing legal contracts and regulations. It is to be used to delineate more clearly the foundation of principles that have and will continue to inform critical incident reporting for recipients of behavioral health services. This document replaces previously distributed, training and instructional materials for Behavioral Health Critical Incident Reporting. The development of this document included a review of already existing literature including but not limited to:

- New Mexico Administrative Code Incident NMAC 7.1.13 Reporting, Intake, Processing and Training Requirements
- Managed Care Policy Manual, January 1, 2014,
- NMAC 8.308.2 Specialized Behavioral Health Provider Enrollment and Reimbursement
- NMAC 7.20.11 Certification Requirements For Child And Adolescent Mental Health Services
- HSD and other training material previously developed and utilized.

Behavioral Health Critical Incident reporting is part of ensuring that all New Mexico adults and children are receiving quality healthcare services through Centennial Care and that they are free from abuse, neglect, and exploitation. It is expected that providers of services have a robust quality assurance program that includes management of critical incidents. Ensuring quality of service is a means for continued evaluation and risk management.

A reportable Behavioral Health Critical Incident is defined as:
A reportable event is any Sentinel event defined as an "unexpected" occurrence involving death or serious physical or psychological injury. "Serious injury" specifically includes loss of limb or function. Please see Terms and Definitions on page 8, for clarification.

WHY

Critical Incident reporting is a mechanism to ensure the health and safety of State of New Mexico consumers who are receiving behavioral health services through contracts with Managed Care Organizations (MCOs), Fee for Service providers or with the State's Administrative Service Organization (ASO). Reporting facilitates a process of ongoing evaluation to address concerns that help improve service quality by identifying important issues. Principles and regulation that further inform reporting requirements:

- Staff must receive initial and ongoing training to be competent to respond to, report, and document incidents, in a timely and accurate manner.

- Recipients, legal representatives, and guardians must be made aware of and have available incident reporting processes.

- An incident must be reported before it can be investigated.

- New Mexico State law requires reporting alleged incidents.
    - Adult Protective Services (APS) – NMSA 1978, Chapter 27 Public Assistance, Article 7 Adult Protective Services, and NMAC 8.11.3, http://www.nmcpr.state.nm.us/nmac/parts/title08/08.011.0003.htm
    - Department of Health - 7.1.13 NMAC, http://www.nmcpr.state.nm.us/nmac/parts/title07/07.001.0013.htm
    - Human Services Department, http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx and http://www.nmcpr.state.nm.us/nmac/parts/title08/08.308.0021.htm
    - Children, Youth and Families Department http://164.64.110.239/nmac/parts/title07/07.020.0011.htm

Other resources regarding requirements for reporting incidents in New Mexico are listed below. Be sure to check the proper regulations, with your MCO contractors, and state entities with which you are working on specific or unique reporting requirements. A referral to the specific agencies may be required:

- Department of Health- Division of Health Improvement (Developmental Disability Waiver & Medical Fragile) DHI - DOH/DHI/IMB:
  Phone: 505-476-9012
  Fax: 800-584-6057
  https://nmhealth.org/about/dhi/ane/racp/
  Hotline to report abuse: 800-445-6242

- Children, Youth and Families Department (CYFD), Program Operations Bureau (POB): Providers of Residential Treatment Services, Group Home Services, Treatment Foster Care, Day Treatment Services, Comprehensive Community Support Services, Behavior Management Services, Crisis Shelter services must contact their LCA liaison. https://cyfd.org/licensing-certification

- Children, Youth and Families Department (CYFD), Child Protective Services (CPS) Statewide Central Intake (SCI) at
  Phone: 1-855-333-SAFE [7233] or #SAFE from a cell phone
  Fax: 505-841-6691
  http://cyfd.org/contact-us

  http://www.nmcpr.state.nm.us/nmac/parts/title08/08.008.0002.htm
  http://cyfd.org/child-abuse-neglect/reporting-abuse-or-neglect
  http://cyfd.org/behavioral-health

- Office of the State Auditor: Fraud, Waste, and Abuse of Public Resources
  Phone: 1-866-OSA-FRAUD (1-866-672-3728) or 505-476-3800
  http://www.saonm.org/special_audits_investigations

WHO

Any individual who, in good faith, reports an incident or makes an allegation regarding abuse, neglect, or exploitation will be free from any form of retaliation.

For any consumer involved in a critical incident:

1. For whom the services are paid by:
    a. Medicaid through a managed care organization (MCO) including Fee for Service BH funding, OR
    b. BH funding through an Administrative Service Organization provider (ASO), AND
2. That consumer is or has been receiving one of the services below; AND
3. Is or has been in your care, your agency's care, or been referred out to another provider by you in the last 30 days and is not considered discharged

You are required to report the incident in the context of the What, When, and How.

Services:
ACT – Assertive Community Treatment
Acute Inpatient Hospitalization
ARTC – Accredited Residential Treatment Center
BHA – Behavioral Health Agency
BMS – Behavior Management Services
CCSS – Comprehensive Community Support Services
CMHC – Community Mental Health Center
CSA – Core Service Agency
Detox (Excluding Medical Detox)
DT - Day Treatment
GH - Group Home
IHS- Indian Health Services
IOP – Intensive Out-Patient
MST – Multi Systematic Therapy
OTP- Opioid Treatment Program
PSR – Psycho Social Rehabilitation
RTC – Non-Accredited Residential Treatment Center
TFC I – Treatment Foster Care
TFC II – Treatment Foster Care
TLS – Transitional Living Services
Rural Health Centers
Other Certified Services (specify)
Other Outpatient Service (specify)

PROCESS

Proceed through the next set of pages in this document for clarification on additional considerations for reporting including the what, when, where and how.

WHAT

A reportable Behavioral Health Critical Incident:
A reportable event is any Sentinel event defined as an "unexpected" occurrence involving death or serious physical or psychological injury. "Serious injury" specifically includes loss of limb or function.

WHEN

A behavioral health provider/agency delivering an authorized service must submit incident reports within 24 hours of knowledge of the occurrence or in the event that an incident occurs on a weekend or holiday, report the incident next business day, NMAC 7.1.13.7 to the appropriate State designations and/or MCOs. Other reporting requirements may be applicable with respect to APS, CPS, LCA, or professional licensing boards. Be familiar with those if you are working with children or adults that fall under special protections.

WHERE & HOW

This document is to assist providers in filing critical incidents for those members whose category of eligibility falls outside of these fourteen categories that are reported on the HSD Critical-Incident-Portal.

For approval to access the HSD Critical Incident Portal email: HSD-QB-CIR@state.nm.us for credentials. The HSD Critical-Incident-Portal is located at: https://criticalincident.hsd.state.nm.us

The process for submitting reports include fax and/or secure email for all Categories of Eligibility (COEs) outside of these 14. When filing with each MCO please refer to the following information:

The following categories of eligibility are reportable via the HSD portal:

- 100 **with NFLOC**
- 200 **with NFLOC**
- COE 81
- COE 83
- COE 84
- COE 90
- COE 91
- COE 92
- COE 93
- COE 94
- COE 95 *
- COE 001
- COE 003
- COE 004

* Although COE 095 is listed on the HSD CIR Portal as being reportable through that website, the correct method for reporting CIRs associated with COE 095 is to report to the NM Department of Health (DOH) Incident Management Bureau (contact information listed below).

The categories of eligibility 095 (Medically Fragile Waiver) or 096 (Developmental Disability Waiver) should be reported to:

- NM Department of Health (DOH) Incident Management Bureau:
  Phone: (800) 445-6242
  Fax: 505-584-6057

If not using the HSD Critical Incident Portal, the written form can be submitted via below:

- Centennial Care – Medicaid with MCO:
  - Blue Cross Blue Shield (BCBSNM) – Phone: 855-699-0042, Fax: 505-816-5831
    Email: HCSC_BCBS_SPHI@bcbstx.com
  - Molina – Fax: 855-260-8737
    Email: MolinaNewMexicoCIR@Molinahealthcare.com
  - United Health Care (UHC) – Fax: 866-751-2449
    Email: qm-nm@uhc.com
  - Presbyterian – Fax: 505-213-0686
    Email: Criticalincident@phs.org

- Human Services Department/ Medical Assistance Division: - Fee-For-Service, Fax: 505-827-3126
- Children Youth and Family Department/ Program Operations Bureau: For a service licensed or certified by CYFD/POB fax report to 505-827-4595

All CIRs sent on behalf of non-Medicaid clients should be reported to BHSD via fax to: 505-476-9272.

The CIR Form and CIR Protocol can be found on the HSD website:
http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx

If there are questions about critical incident reporting for BHSD clients, send these to:
bh.qualityteam@state.nm.us

If there are questions about critical incident reporting or COEs for Medicaid clients, send these to: HSD-QB-CIR@state.nm.us

TERMS AND DEFINITIONS of SENTINEL EVENTS

Sentinel Events are drawn from the Joint Commission standards are broadly defined as an occurrence involving death or serious physical or psychological injury, or the risk thereof. The sentinel events listed below appear on the Critical Incident Reporting form-Appendix A and should be reported to BHSD.

- Severe Harm
  - Permanent harm
  - Severe temporary harm
    - Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.
  - Consumer towards other, not involving law enforcement.

- Missing recipients
  - Abduction
    - Abduction of any individual served receiving care, treatment, or services.
  - Elopement
    - Any elopement (that is, unauthorized departure) of a consumer from a staffed around-the-clock care setting (including the ED) leading to the death, permanent harm or severe temporary harm of the individual served.

- Sexual Incidents
  - Sexual abuse/assault (including rape) as a sentinel event is defined as nonconsensual sexual contact involving a consumer and another consumer, staff member, or other perpetrator while being treated or on the premises of the organization, including oral, vaginal, or anal penetration or fondling of the consumer's sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine that it is a sentinel event:
    - Any staff-witnessed sexual contact as described above
    - Admission by the perpetrator that sexual contact, as described above, occurred on the premises
    - Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact.
  - Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any individual served receiving care, treatment, or services while receiving services at the organization
  - Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization.

- Flame or unanticipated smoke, heat, or flashes occurring during an episode of patient care.
  - Unsafe condition which creates, or may create, a threat to the life, health, or safety of the recipient.

- Death
  - Unknown- requiring follow up with Office of Medical Examiner
  - Suicide of any individual served currently receiving care, treatment, or services at an agency or provider or within 72 hours of discharge, including from an organization's emergency department (ED).
  - Medication/treatment error(s)
    - Under or overdose or medication errors requiring treatment.
  - Natural causes
  - Accident
  - Secondary to use of restraints
    - Including restraints, seclusion, and therapeutic holds.
  - Member death by homicide

Tip Sheets for practitioners In integrated Care Settings

Practice Principles and Functions for Use in Certified Community Behavioral Health Centers

To Support Wellness, Youth Resiliency, and Adult Recovery

Technical Review Version 1.3d: March 2016

LISTING OF TIP SHEETS PROVIDED IN THIS PACKET

LISTING OF TIP SHEETS BY TOPICS ADDRESSED

Guiding Principles for Providing High Quality Practice

GUIDING PRINCIPLES. High quality practice is: • Person-centered. • Strengths-based. • Solution-focused. • Wellness-, resiliency- and recovery-oriented • Trauma-informed. • Outcome-focused and results-driven.

Key Concepts

Person-Centered. Person-Centered Care is an approach designed to assist someone in planning and achieving life goals and supports. It was originally used as a life planning model to enable individuals with disabilities and requiring support to increase their personal self-determination and improve their own independence. It is accepted as evidence based practice. Person-centered care is currently becoming the standard in many areas of practice and is the guiding philosophy behind the integration of medical and behavioral health care. It is evident that individuals and families are more invested in any process where they feel they are an integral part. Self-Directed Care is built upon person-centered care principles and practices.

Strengths-Based. Strengths-based practice is person-centered, with a focus on future outcomes and strengths that the people bring to a problem or crisis. This approach enhances the capacities of individuals and families to deal with their own challenges. Key features of this approach include:

- Strengths-based practice assesses the inherent strengths of a person or family and then builds on those strengths when addressing life changes, recovery and empowerment.
- It avoids the use of stigmatizing language or terms that families use on themselves and eventually identify with, accept, and feel helpless to change.
- It fosters hope by focusing on what has been historically successful for the person and builds on these past successes to support positive future changes.
- It inventories the positive building blocks that already exist in his/her environment that can serve as the foundation for growth and change.

Solution-Focused. This approach is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought the person to seek help. It targets the desired outcomes of intervention as a solution rather than focusing on the symptoms or issues identified at intake. This technique gives attention to the present and the future desires of the person, rather than focusing on the past experiences. The practitioner encourages the person to imagine their future as they want it to be and then the practitioner and person collaborate on a series of steps to achieve that goal. Solution-focused practice aims to bring about the person's or family's desired change in the least amount of time.

Wellness-, Resiliency-, Recovery-Oriented. To provide effective interventions, the practice used for a youth or an adult should support wellness, youth resiliency, and adult recovery: • Wellness is an active process in which a person becomes aware of and makes choices toward a more healthy and successful existence. Wellness is a conscious, self-directed, and evolving process of achieving full potential which is multidimensional and holistic, encompassing lifestyle, physical, mental and spiritual well-being, and the environment. • Resiliency is the process of managing stress and functioning well when faced with adversity or trauma. Youth are resilient when they are able to use their inner strengths to positively meet challenges, manage adversities, heal from the effects of trauma, and thrive in life given their unique characteristics, goals, and circumstances. A youth's resilience (self-efficacy) is aided by a trusting relationship with a caring, encouraging, and competent adult who provides positive guidance and promotes high expectations. • Recovery is a process through which persons improve their health and wellness, live a self-directed life, and strive to reach their full potential. Intervention and goals are developed in accordance with the guiding principles of recovery, which are: hope, person-driven, holistic, peer supported, relational, responsive to culture and to trauma, focused on strengths and responsibility, and respectful.

Trauma-Informed. To provide trauma-informed care to youth or adults receiving services, practitioners should understand the impact of trauma on child development and on adult behavior and learn how to effectively minimize its effects without causing additional trauma. A growing body of evidence indicates maltreatment can alter brain functioning and consequently affect mental, physical, emotional, and behavioral development (often called socio-emotional development). Early intervention by human service practitioners provides the opportunity to identify a youth's developmental concerns and help families receive the support they need to reduce any long-term effects. Practices for providing trauma- informed care should be used for adults who have experienced complex trauma and who have lingering adverse affects of trauma today.

Outcome-Focused and Results-Driven. Desired outcomes guide the intervention process and can best be stated as life-change outcomes (related to well-being, essential supports, daily functioning, and/or role fulfillment). Goals are used by the person and his/her team to select strategies, supports, and services for working toward goal attainment. Delivery of intervention strategies and supports is carefully tracked to determine: 1) whether the strategies and supports are being provided in an adequate manner; 2) whether the strategies are working or not working based on progress being made; and, 3) whether the outcome has been met. Case practice decisions are informed by the progress (or lack of progress) being made toward the attainment of planned goals, and when a strategy or provider of the strategy is not working effectively, the practitioner quickly recognizes the failure and promptly replaces the provider or strategy.

Practice Wheel: Practice Functions Illustration

Case Practice Is Performed to Produce Positive Life Changes for Persons Served

Public service systems exist to help citizens experiencing life-disrupting needs or threats of harm to get better, do better, and stay better in daily life. The collective set of actions used for interventions to alleviate the needs or threats is referred to as *practice*. The purpose of practice is helping a person in need or at risk of harm to achieve and maintain, where necessary, adequate and ongoing levels of:

- Well-being (e.g., safety, stability, physical and emotional health, sobriety, recovery)
- Essential supports for daily living (e.g., housing, food, income, health care, child care),
- Daily functioning (i.e., basic tasks involved in daily living, as appropriate to a person's life stage and ability)
- Fulfillment of key life roles (e.g., a youth being a successful student or an adult being a successful parent or employee).

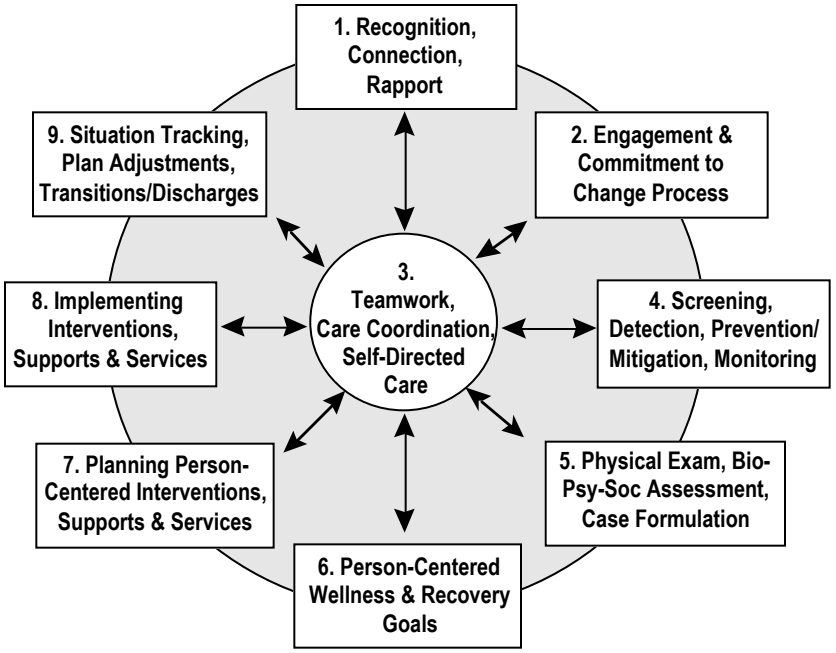
Typical functions in a practice model include engagement, understanding, defining the results to be achieved, selection and use of life change strategies and supports, resourcing and delivery of planned strategies, and the tracking and adjusting strategies until desired outcomes are achieved.

A Case Practice Model Defines Functions Used by Practitioners to Get Results

A public agency's Practice Model defines basic functions used by frontline practitioners to join with persons receiving services to bring about a positive life change process that helps them get better, do better, and stay better. It encompasses the core values of the agency (e.g., use of person-centered care principles) and defines the fundamental expectations concerning working relationships, integration of efforts among the practitioners serving a person in need, and essential action patterns or functions associated with effective case practice. An agency's Practice Model becomes a central organizer for training of frontline staff, supervision, performance measurement, and accountability.

The *practice wheel* shown shown below illustrates basic practice functions typically used by agencies serving adults for reasons of improving wellness, youth resiliency, adult recovery, and greater independence from public service systems.

Practice Wheel: Functions in Integrated Care Practice



Practice Functions May Occur Interactively, Concurrently, and Progressively

Desired Outcomes of Practice

RECOGNITION, CONNECTION & RAPPORT: • The person's sense of identity, culture, values and preferences, social network, and life experiences are recognized by practitioners involved with the person. • Any barriers to personal connection and acceptance are recognized and resolved. • Necessary conditions for building mutual respect and rapport are established as a basis for successful engagement.

Key Concepts

Building a relationship with a person entering services requires practitioners to recognize the nature of the person's situation and life story and to discover the circumstances that have brought the person into agency services. One of the most important first steps is recognition of any barriers that could thwart formation of positive connections with the person which could undermine acceptance and rapport building necessary for successful engagement.

Practitioners should take steps for creating conditions necessary for building mutual respect and rapport required in developing trust-based working relationships. Also key to successful engagement and connection is the recognition of the person's sense of identity, culture, values and preferences (especially any arising from race, sexual identity, and/or religious conviction), social and economic supports, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, addiction, emigration, poverty) that explain the person's life story and reasons for entry into services.

Persons coming into service require use of culturally relevant and responsive interactions and interventions in order to successfully connect, educate, assist, and support them moving through the system. Responsiveness includes valuing cultural diversity, understanding how it impacts family functioning in a different culture, and adapting service processes to meet the needs of culturally diverse groups of persons receiving services. Properly applied in practice, cultural responsiveness reduces the likelihood that matters of language, culture, custom, identity, value, or belief will prevent or reduce the effectiveness of life change efforts undertaken via interventions, supports, and services. A person's identity [e.g., race, tribe, ethnicity; social group; sexual orientation; religion; or disability, such as deafness] may shape his or her world view and life goals in ways that must be understood and accounted for in practice. Recognition, connection, and rapport provide a foundation for building and sustaining trust-based working relationships.

Practice Tips

1. Learn the reason the person is seeking help. Consider whether the person's problem can be resolved in a single visit or brief intervention. Determine whether the person's problem is emergent/transient or serious/persistent. Determine whether the reported problem is a present threat to health or safety so that any need for crisis intervention or urgent response can be identified and provided.

2. If the person reports being in physical pain or emotional distress, ask about its nature, source, history, and impact on the person's life situation. Use the person's responses to form a theory that explains how the pain or distress came about, what causes it to continue, what has been done to alleviate it in the past, what has worked/not worked before, and who else may be helping the person relieve or solve this problem now.

3. In early interactions, discover the person's sense of identity, language, culture, values and preferences (especially any arising from race, sexual identity, and/or religious conviction), world view, social and economic supports, strengths and needs, present life challenges, and life-shaping experiences (e.g., adverse childhood experiences, deteriorating physical health, combat trauma, recent loss, addiction, emigration, poverty) that explain the person's situation and reasons for requesting help.

4. Recognize any barriers (arising from culture, language, gender, class, religious or political beliefs, life experiences, sexual orientation, work or family demands, or disability) that could thwart or limit the formation of positive connections with the person that would undermine acceptance and rapport building necessary for developing successful trust-based working relationships.

5. In summary, take active steps in establishing positive conditions for connecting with the person and building mutual respect and rapport with the person. Remember: recognition, connection, respect, and rapport are the building blocks of a trust-based working relationship and are performed concurrently by the practitioner when a person is entering services.

Desired Outcomes of Practice

ENGAGEMENT & COMMITMENT. • Service providers are building and maintaining a trust-based working relationships with the person and the person's informal supporters to involve them in ongoing assessment, service planning, and wellness and recovery efforts. • Service providers are using effective outreach and ongoing engagement strategies to increase and sustain the person's participation in the service process and commitment to life changes that support wellness and recovery, consistent with the person's needs and preferences.

Key Concepts

Effective wellness and recovery services depend on ongoing working relationships between a person in need and the service providers who help meet those needs. Service providers make concerted efforts to reach out to the person, engage him/her meaningfully in all aspects of the service process, establish and maintain a trust-based working relationship that is consistent with the person's language and culture, coordinate efforts with other providers and secure and sustain the person's commitment to a change process. Engagement strategies build a mutually beneficial partnership in decision-making and life change efforts. The person's direct, ongoing, active involvement is used in assessment, planning interventions, selecting providers, monitoring and modifying service plans, and evaluating results.

Practice approaches that support effective relationship building are:

- Person-centered (organizes around the person's goals)
- Strengths-based (builds on the person's positive assets)
- Solution-focused (moves from problems to solutions)
- Need-responsive (recognizes and responds to needs)
- Wellness-oriented and outcome-driven (starts with the end in mind)
- Builds readiness for change (uses motivational interviewing strategies)
- Fits the person's stages of change (starts where the person is ready)
- Respects the person's identity, culture, aspirations, and preferences

In the absence of a trust-based working relationship with the service provider, the person is unlikely to reveal the underlying issues that explain the dynamic circumstances causing the problem that must be solved in order to achieve desired wellness and recovery outcomes.

Building Commitment to Positive Life Change. A major contribution of effective engagement is building and sustaining the person's commitment to personally chosen wellness and recovery outcomes and to the change process used to achieve these outcomes. In the absence of the person's commitment to life change, wellness and recovery outcomes are not likely to be achieved.

Practice Tips

1. Remember that building a relationship with a person involves recognizing the nature of the person's life situation and reasons for requesting help. Listening is key to learning, empathy, respect, and trust building. Finding and overcoming any barriers to personal connections are essential. Recognition and rapport provide a foundation for building and sustaining a trust-based working relationship.

2. Use a person-centered approach that puts the person's voice and choice at the center of the service process. Recognize and respond to the person's unmet needs related to wellness, well-being, and daily functioning. Use a solution-focused approach that is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought the person to seek help. Solution-focused practice aims to bring about the person's desired change in the least amount of time. Strengths-based practice approach emphasizes a person's self-determination and identifies and builds upon the person's strengths and assets to create sustainable resources for solutions.

3. Change-oriented approaches are especially useful in addressing lifestyle modification for risk reduction, disease prevention, long-term disease or disorder management, and addiction. Understanding a person's readiness to make change, appreciating barriers to change, and helping anticipate relapse can improve the person's satisfaction and lower practitioner frustration during the change process. A stengths-based, solution-focused change approach is useful in stimulating positive change and overcoming resistance.

4. Remember that engagement is an ongoing process that builds and sustains: 1) a mutually beneficial trust-based working relationship between the person and 2) a person's commitment to personally selected wellness and recovery outcomes and to the life change process.

Desired Outcomes of Practice

SCREENING, DETECTION, PREVENTION/MITIGATION, MONITORING. • Screening detects imminent threats to the person's health, safety, supports, or behavioral well-being upon entry and ongoing thereafter. • Responsive actions are provided in a timely and appropriate manner to prevent or mitigate any foreseeable harm to the person or others around the person arising from the detected threats of harm, risks of near-term life disruptions, or risks of poor well-being outcomes. • Follow-along monitoring tracks the person's situation to detect and respond to any future threats to well-being.

Key Concepts

A timely and appropriate response is provided for a person who is detected via screening processes or self-report as has having a threatening life situation, behavioral condition, disorder, or disease for which intervention or treatment is indicated, possibly with urgency.

Screening & Detection. Screenings are performed to identify a person who may have an undiagnosed health or behavioral condition or who may be at high risk of developing a condition requiring treatment, and to identify any imminent threat of harm from life partners/caregivers creating a major breakdown in essential supports. Screenings include labs to detect health problems as well as screening activities used to identify safety threats, behavioral concerns, and breakdowns in essential supports. Screenings may include metabolic syndrome factors, HIV, Hep-C, thyroid issues, depression, drug and alcohol use, suicide/homicide risks, trauma including domestic violence, and fall risk for the elderly. Detection involves identification of a specific health problem, safety threat, behavioral concern, or support breakdown that could cause harm:

- Safety / threats of harm at home, work, or school
- Adverse childhood experiences / complex trauma
- Emotional status / behavioral disorders
- Health status / physical well-being / illness
- A pattern of instability / trajectory of physical or emotional decline
- Self-endangerment / threats of harm to others
- Intellectual or developmental disability / TBI / learning problems
- Drug or alcohol use
- Unstable living situation or major break-down in key supports
- Diseases: diabetes, COPD, obesity, hypertension, seizures, thyroid issues, Hep-C, HIV, other

Prevention or Mitigation and Follow-Along Monitoring. Following detection of a threat of harm or an emergent condition, a response is an action taken to avert a safety threat, stop the progression of a disease, control a behavioral disorder, or to mitigate preventable injury or illness. The response must match the urgency, severity, and intensity of a detected problem, especially when the person is at imminent risk of harm (e.g., sudden death via suicide) or at high risk of a poor health outcome (e.g., a brittle diabetic adolescent who violates dietary restrictions).Prevention strategies keep harmful things from happening. Mitigation strategies reduce risks or minimize adverse effects of something that is already happening. Follow-along monitoring is used to track risk factors and mitigation strategies used to manage health, safety, behavioral, or support problems in order to provide knowledge for planning next step actions.

Practice Tips

1. Any problem requiring a crisis intervention or urgent response is addressed in a timely, appropriate, and sufficient mannerso as to prevent unnecessary harm, pain, loss, or hardship for the person. Each response provided is commensurate with the urgency and severity of the presenting problem. Any response provided protects the person from preventable harm or mitigates the impact the problem would have likely had if not treated promptly and effectively.

2. Screenings of the person are performed upon admission and periodically thereafter. Practitioners continue to conduct screenings to detect safety, health, and behavioral risks as well as any emergent conditions or disorders as an ongoing assessment process. Based on results of screenings and self-reports by the person, any problems of significance (involving safety, health, or behavioral risks or other situations that could lead to instability or decline) are promptly detected.

3. The nature, significance, and history of any detected problem are defined and reported to any other practitioners or agencies that should be involved in providing an appropriate response to the person's need for prevention, protection, treatment, or care.

4. Results of initial and ongoing screenings are incorporated into the ongoing Bio-Psycho-Social Assessment and Case Formulation involving the person's situation. Any significant screening and detection results are used to develop necessary protective interventions and/or treatments to keep the person safe, physically and behaviorally healthy, and functioning effectively in daily life.

Desired Outcomes of Practice

ASSESSMENT & CASE FORMULATION. • Ongoing formal and informal fact finding methods are used to develop and update a broad-based understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. • An evolving clinical case formulation (describing the person's clinically significant distress and impairment in functioning) is used to guide development of treatment plans informed by the person's life stage, culture, social context, and preferences.

Key Concepts

Ongoing assessment and clinical case formulation guide the course of action designed and used over time by service providers in collaboration with the person being served to help her/him meet wellness and recovery goals that have been selected. Assessment provides answers to practical and clinical questions [see the Tip Sheet on Organizing Questions] that are used to develop a functional, working understanding for the person from which treatment decisions are made. Based on the working understanding, a clinical case formulation is developed and updated as new understandings emerge.

Assessment & Understanding. As appropriate to the person's situation, a combination of clinical, functional, and informal assessment techniques are used to determine the strengths, needs, risks, underlying issues, and future goals of the person. Once gathered, the information is analyzed and synthesized to form a functional understanding and a bio-psycho-social based clinical case formulation used in developing a course of action with and for the person. Areas in which essential understandings are developed include:

- Earlier life traumas, losses, and disruptions
- Learning problems affecting school or work performance
- Subsistence challenges encountered in daily living
- Risks of harm, abuse, neglect, intimidation, or exploitation
- Traumatic brain injury and/or intellectual disabilities
- Court-ordered requirements/constraints/detention
- Recent life disruptions (e.g., eviction, bankruptcy)
- Dislocation due to natural disaster or changes in the local job market
- Co-occurring life challenges (cultural issues, mental illness, addiction, deafness, domestic violence)
- Significant physical health and/or behavioral health concerns
- Recent tragedy, trauma (including combat trauma), losses, victimization
- Problems of attachment, bonding, self-protective boundaries in relationships
- Recent life changes (e.g., new baby, job loss) requiring major adjustments
- Any significant screening and detection findings (health or safety risks)

Case Formulation and Clinical Reasoning. Understandings developed from ongoing assessments are used to create a clinical case formulation that guides service decisions and actions. Clinical reasoning is applied in moving from understanding to action: Any compelling urgency is addressed first. Practical solutions may precede clinical solutions in the course of action. Opportunities for early and repeated successes are identified and pursued. A pace of action that could confuse or overwhelm the person is avoided.

Practice Tips

1. The outcome of assessment is a functional understanding of the person's situation used to build a clinical case formulation that guides goal setting and intervention planning. Assessment is a continuous learning process that includes gathering and assembly of facts, information, and knowledge to develop a broad-based understanding of the person's situation used to support decision making. Remember that screening data, detection of threats to the person's well-being, results of prevention or mitigation strategies, follow along monitoring findings, and evaluation of results are used in the ongoing assessment process.

2. A clinical case formulation includes a clinical history and concise summary of the bio-psycho-social factors contributing to the present concern. It focuses on clinically significant distress and impairment in functioning experienced by the person. The case formulation considers the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern.

3. Practical reasoning and clinical judgment are used in making a reliable assessment of factors related to a person's disruption in daily functioning or role fulfillment.

4. Functional understandings and a clinical case formulation are used to guide development of a comprehensive treatment plan, including support plans where indicated, informed by the person's life stage, culture, social context, and preferences.

ORGANIZING QUESTIONS FOR USE IN ASSESSMENT & CASE FORMULATION

ORGANIZING QUESTIONS IN CLINICAL REASONING

Presented below is a set of basic practical and clinical reasoning questions offered for use by practitioners, clinicians, and supervisors to guide practical and clinical reasoning in case practice. Answers to these questions can help focus the organization of assessment information and clinical case formulation as well as guide outcome and intervention planning. It is not meant to be an all inclusive or exhaustive set of probes and thought organizers to cover every possibility. There may be other important matters in any case situation that are not addressed in this set of questions. Practitioners should remain alert to those situations.

1. **People Involved:** • Who are the people involved in supporting and serving this person? • How well are they engaged, involved, and committed to helping the person?

2. **Expectations and Voice & Choice**: • What outcomes of intervention are people expecting to be achieved? • The person? • The person's caregiver or key supporters? • The school or employer? • The medical provider? • The court? • Other service providers? • To what degree are the voices and choices of the person and the person's supporters influencing decisions are about the person's needs and preferences in the service process?

3. **Causes & Contributors of Presenting Problems**: • What bio-psycho-social factors, life circumstances, and underlying issues explain the person's presenting problem(s), clinically significant distress, impairment in functioning, and currently unmet needs?

4. **Risk Factors**: • Based on history and tendencies, what things could go wrong in this person's life? • What must be done to avoid or prevent future harm, life disruption, pain, loss, or undue hardship?

5. **Functional Strengths & Assets**: • What are the person's functional strengths, aspirations for change, and life assets that can be built up to solve the problem(s) that brought the person into services?

6. **Critical Unmet Needs**: • What critical unmet needs would have to be fulfilled in order for the person to get better, do better, and stay better?

7. **Points of Consensus & Dispute**: • On what key matters do the people involved agree at this time? • What key matters, if any, may be in dispute by any of the persons involved? • What impact, if any, are unresolved disputes having on decision making about needs, risks, outcomes, interventions, or commitments to the change process?

8. **Necessary Changes**: • What things in the person's life would have to change in order for the person to achieve and maintain adequate well-being, have essential supports for living, function adequately in daily activities, and fulfill key life roles - as appropriate to life stage, capacities, and preferences?

9. **Essential Outcomes**: • What life conditions, when met, will show the person's problems are solved and critical needs are met (e.g., achieved adequate well-being, has essential supports for living, functions adequately in daily activities, and fulfills key life roles)?

10. **Key Opportunities for Rapid Successes**: • What near-term opportunities for getting early and repeated successes are available to strategically target intervention activities that could alter the case trajectory? • In what area is an early completion of a key outcome possible? • In what key areas is a readiness for change evident (based on the stages of change) in the person's present motivation? • How able is the person/family to make choices and self-direct? • How are such opportunities being used to advance efforts to achieve early, positive, and sustained changes for this person?

11. **Intervention Strategies**: • What combination and sequence of intervention strategies are likely to bring about desired life changes and meet the person's wellness or recovery goals? • How well does the pace and workload of interventions activities fit the person's tolerance for scheduling and acceptance of planned activities and ability to self-direct? • How well does the current rate of intervention activity avoid a pace and participation burden that would overwhelm or confuse the person and reduce motivation for ongoing participation and life change efforts?

12. **Intervention Requirements**: • Who will implement the planned intervention strategies and actions? • What will the persons implementing the intervention strategies have to know, believe, have, and do to be successful? • Who will train, support, and supervise the implementers to ensure that the required skills, knowledge, attitudes, coordination, resources, time availability, and commitment are present and used as planned?

13. **Results-Based Decisions**: • How will people know and decide: • Whether interventions are being delivered and are working as planned? • When interventions should be changed or stopped? • When life-change outcomes have been substantially achieved? • When the person's needs are met, key outcomes have been achieved, and intervention efforts can be safely and successfully reduced, transitioned, or concluded? • How thoroughly and consistently the understandings gained about implementation processes and results are being used to evaluate interventions and to adjust the assessment, case formulation, outcomes, and interventions used for this person?

Desired Outcomes of Practice

WELLNESS, RESILIENCY, RECOVERY GOALS. Planned life-change goals for the person: • Are based on understandings developed from current assessments and a clinical case formulation. • Define agreed upon life changes necessary for achieving and maintaining wellness, meeting essential needs, improving daily functioning, gaining greater independence, and supporting ongoing resiliency or recovery. • Are stated as the person's vision for wellness, resiliency, and/or recovery in the person's treatment plan. • Are measurable for tracking progress and determining attainment of outcomes.

Key Concepts

WELLNESS, RESILIENCY, AND RECOVERY GOALS define how all involved in the service process will know that the person is getting better, doing better and staying better in life. Planned goals and life change outcomes specify states of well-being (e.g., safety, health, or substance free lifestyle), functioning (e.g., competency or capacity), or support (e.g., shelter or income) that was absent or insufficient at the time the person entered the service system and that will be necessary for the person to gain and maintain success in life without ongoing assistance from the service system, or when the person is ready to transition from one level of care or living arrangement to another. The creation of a person's wellness and resiliency or recovery goals should be: 1) derived from current assessments and the clinical case formulation, 2) based on collaborative understandings of necessary life changes, and, where appropriate, 3) reflective of any court orders that require specific life changes.

Defining wellness and resiliency recovery goals creates a guiding view for services (working from outcomes to actions) that should precede the planning of intervention strategies and actions used to achieve outcomes. Having clear life outcomes enables the person and those helping the person to see both the next steps forward and the end-point on the horizon -- thus, providing a clear vision of the pathway to wellness and resiliency or recovery.

Practice Tips

1. Use person-centered, wellness/resiliency/recovery-oriented planning techniques to help the person identify and state what he/she expects to gain or achieve from services. Frame expectations as life-change goals using the person's own words. Make sure the goals created to guide service planning are based on the person's assessed needs, expressed aspirations for a better life, and socially-beneficial choices.

2. Consider the logical order in which life-change goals should be addressed. The practitioner should first plan to meet any compelling urgencies requiring immediate action to prevent harm (working from urgent to strategic). After any such urgencies are addressed, focus next on any life-change goals related to achieving well-being (e.g., safety, health, well-being) and goals related to supports for living (e.g., income, food, housing, health care). Once needs for well-being and supports for living are being met, the focus shifts to goals related to improving daily functioning and to fulfilling key life roles. This progression of meeting essential needs and strategic life changes should enable the person to achieve and maintain an adequate daily life situation and gain greater independence from the service system.

3. Discover opportunities available for making early and repeated progress. When selecting from among near-term goals and strategies, the practitioner should give priority to any ready opportunities for getting early and repeated successes and/or any important life outcome that could be easily and readily achieved. Early victories or rapid completions in life change efforts can increase satisfaction and motivation for the person and can have the effect of changing the trajectory of the case.

4. Construct goals that are ***SMART***: **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-bound. Clear, relevant and achievable goals help in planning intervention strategies, in measuring of results, and in promoting the person's motivation and commitment to the change process. Avoid pitfalls in goal setting, such as: • Focusing on a narrow, immediate change rather than a long-term outcome; • Setting negative goals (focusing on stopping a bad behavior rather than focusing on the positive replacement behavior); • Focusing on too few things to solve the main problem being addressed; • Setting more goals than can be addressed at once; • Not setting an estimated completion time for the attainment of the goal; • Creating goals too vague to be measured or completed.

5. Use the person's life-change goals to guide the selection of intervention strategies used for their attainment. Identify goals for which the involvement of other practitioners or agencies will be involved, in or responsible for the helping the person achieve the desired outcomes. Use teamwork to develop consensus on goals (based on common purpose) and build unity of effort among providers in order to coordinate and integrate services for goal attainment.

Desired Outcomes of Practice

TEAMWORK/COMMON PURPOSE & UNITY OF EFFORT. • Using a person-centered decision making process, the person's service providers and supporters are building and sustaining: • Common purpose by planning wellness/ recovery goals and strategies with and for the person. • Unity of effort in service delivery by coordinating actions of the service providers and integrating services across providers, settings, time, and funding sources.

Key Concepts

Person-centered, resiliency- or recovery-oriented practices and self-directed care principles put the person's needs, aspirations, and choices at the center of the service provision efforts. A team-based, shared decision-making process helps the person create a vision for a better life based on aspirations for well- being, supports for living, and improved daily functioning and role fulfillment. Informal supporters and service providers join with the person to define wellness and recovery goals to be achieved along with related strategies for provision of supports and services. Because the efforts of many may be involved in helping the person, achieving common purpose and unity of effort are essential for success, and will create the "glue" that holds things together in practice for the benefit of the person receiving services.

Common Purpose. Common purpose is created when the person and service providers involved agree upon and commit to clear goals and a related course of action. An ongoing, person-centered/resiliency- or recovery-oriented, team-based, shared decision-making process may be used to achieve and maintain a CONSENSUS and COMMITMENT to a set of well-planned goals and related strategies which are essential for building common purpose.

Unity of Effort. Unity of effort is based on: (1) A common understanding of the person's situation; (2) A common vision for a better life; (3) Coordination of efforts to ensure coherency and continuity; (4) Common measures of progress and ability to change course, if necessary. Unity of effort is achieved and maintained via ongoing teamwork, coordination of actions among the person, providers and supporters, and integration of services across providers, settings, funding sources, and points in time.

Practice Tips

1. Remember that effective TEAMWORK and SERVICE COORDINATION help build common purpose and unity of effort in frontline practice. Effective teamwork involves having the right people working together with and for the person being served. The team should have the technical and cultural competence, the knowledge of the person, the authority to act on behalf of funding agencies and to commit resources, and the ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person.

2. The team assists in conducting person-centered planning activities and in providing assistance, support, and interventions after plans are made in order to meet important goals. Working together, team members support the person in identifying needs, setting goals, and planning strategies with related services that will enable the person and family to meet those goals. Effective, ongoing, collaborative problem solving is a key indicator of effective team functioning.

3. Leadership and coordination are necessary to: (1) form a person-centered team and facilitate teamwork; (2) plan, implement, monitor, modify, and evaluate services provided; (3) integrate strategies, activities, resources, and interventions agreed upon by the team; (4) measure and share results in order to change strategies that do not work and to determine progress; and (5) ensure a unified process involving a shared decision-making approach. While leading and coordinating may be appropriately discharged by a variety of team members, it is most effectively accomplished by a designated leader (e.g., a care coordinator) who prepares team members, convenes and organizes meetings, facilitates team decision-making processes, and follows up on commitments made. Individual(s) filling these roles should have strong facilitation skills, authority to act, and, as appropriate to role, clinical skills in assessing, planning, monitoring, and evaluation. In a case where several agencies and providers are involved, negotiation may be necessary to achieve and sustain a coordinated and effective service process. Leadership and coordination responsibilities can be shared with an empowered and capable service recipient in order to increase self-direction of care.

3. Team functioning and decision-making processes should be consistent with principles of person-centered care, resiliency- or recovery-oriented practice and, where possible self-directed care. Evidence of effective team functioning over time is demonstrated by the quality of relationships built, the commitments fulfilled, results achieved, the unity of effort shown by all members of the team, the focus and proper fit of services assembled for the person, the dependability of service system performance, and the connectedness of the person to critical resources necessary for achieving important life goals.

Desired Outcomes of Practice

PLANNING. • Meaningful, measurable, and achieveable wellness/resiliency/recovery goals for the person are supported with well-reasoned, agreed-upon strategies, supports, and services planned for their attainment.

Key Concepts

Interventions consist of a combination and sequence of planned strategies, supports, and services which guide implementation toward life changes for a person leading to the attainment of wellness and recovery goals identified by the person and team. Intervention planning is an ongoing process throughout the life of the case, and planned interventions should be consistent with the person's aspirations for a better life.

Practice Tips

Planned intervention strategies, supports, and services related to a person's wellness and recovery goals may be developed in one or more the following areas where co-occurring needs are identified.

1. **Physical Wellness** - focuses on planning for achieving and maintaining the person's best attainable health status by managing any health concerns. The person may need assistance to access services necessary to manage chronic health conditions (e.g., seizures, COPD, diabetes, obesity, hypertension, thyroid issues, Hep-C, HIV/ AIDS, etc.) that require involvement of practitioners from primary health care and other health care specialties.

2. **Mental Health Resiliency or Recovery** - focuses on reducing and managing psychiatric symptoms that impair daily functioning. Use of psychiatric medication in combination with counseling and supportive services are common intervention strategies used to reduce symptoms and build coping skills.

3. **Addiction Recovery** - addresses various aspects of substance use, relapse prevention and addiction recovery. Careful identification of co-occurring issues is essential for effective planning.

4. **Trauma Recovery** - addresses the lingering adverse effects of complex trauma. Trauma recovery may involve processing trauma-related memories and feelings, discharging pent-up "fight-or-flight" energy, learning how to regulate strong emotions via new coping skills, and rebuilding the ability to trust other people. Trauma recovery is a process that may involve safety planning, cognitive behavioral strategies, social supports, and medication.

5. **Safety from Harm** - applies to planning strategies for keeping persons safe, including no contact orders, and safety plans, crisis responses, and/or safety supports. A behavioral crisis is one in which the person presents behaviors that put himself or others at risk of harm. A health crisis is one in which a chronic health condition suddenly becomes acute, putting the person's life at risk unless immediate medical care is provided. A safety crisis is a situation in which another person through intention and action or inaction puts the focus person at risk of harm, injury, or death.

6. **Income & Basic Necessities** - includes strategies for work, earned income, securing and managing benefits, obtaining housing, food stamps, housing, income maintenance, health care, medicine, or child care. Securing such supports, when they are lacking, may be necessary for the person's well-being, daily living, and for some adults, maintaining family functioning.

7. **Functional Life Skills Development** - involves skill-specific training and direct support to acquire, apply, and sustain functional life skills in daily living situations. Functional life skills include such elements as activities of daily living (ADLs), managing health issues and medication, and managing behavioral issues via effective coping skills. Functional skills are needed for successful everyday living and fulfilling important life roles, such as parenting dependent children or adults in the person's care.

8. **Education or Work** - includes education, career development, volunteering as a productive activity, and work, either competitive or supported.

9. **Community Integration** - or most adults, recovery includes regaining degrees of community integration, which involves making decisions about choice of social supports and life activities. Experiencing life activities in mainstream settings outside of an institution or provider agency that involve having interactions with non- disabled persons who are engaged in the same activities may be an important part of the plan (e.g., attending a ball game, eating in a cafe, riding a public bus, voting in an election).

Desired Outcomes of Practice

IMPLEMENTING. Planned strategies, supports, and services are delivered in a manner sufficient to help the person make adequate progress toward meeting planned goals. • The combination of supports and services fits the person's situation so as to maximize benefits and minimize any conflicting strategies or inconveniences.

Key Concepts

Implementation provides for the timely, competent, and consistent delivery of planned interventions (strategies, supports, services) in ways that are consistent with the goals set by and for the person, convenient for the person and family, and sufficient in power and effectiveness to bring about the life changes that lead to goal attainment. Implementation follows and flows from the strategies, supports, and services specified in person's treatment and support plans.

Practice Tips

Implementation of intervention strategies, supports, and services may be occur in one or more the following areas.

1. **Physical Wellness** - focuses on achieving and maintaining the person's best attainable health status. This includes managing any health concerns by helping the person access services necessary to manage chronic health conditions (e.g., seizures, COPD, diabetes, obesity, thyroid issues, hypertension, Hep-C, HIV/AIDS, etc.) that require involvement of practitioners from primary health care and other health care specialties in the ongoing monitoring and coordination of multiple treatment modalities for the person. Strategies in this area involve not only the health care practitioners but also those supportive persons (e.g., the person, caregiver, health educator, care coordinator, and/or community support worker) having important roles in health education, transportation, medication administration, and meeting other daily health maintenance requirements.

2. **Mental Health Resiliency or Recovery** - focuses on reducing and managing psychiatric symptoms that impair daily functioning. Use of psychiatric medication in combination with counseling and supportive services may be interventions used to reduce symptoms and build coping skills.

3. **Addiction Recovery** - addresses various aspects of substance use dependence treatment, relapse prevention, and addiction recovery. An adult having a co-occurring disorder (depression and opiate addiction) could have several strategies used for achieving and maintaining sobriety and reduction in symptoms of depression. Use of psychiatric medications to treat depression and Suboxone to treat opiate addiction are common dual intervention strategies to achieve key outcomes for sobriety and mood stability.

4. **Trauma Recovery** - addresses the lingering adverse effects of complex trauma. Trauma recovery may involve processing trauma-related memories and feelings, discharging pent-up "fight-or-flight" energy, learning how to regulate strong emotions, and rebuilding the ability to trust other people. Trauma recovery is a process that may involve safety planning, cognitive behavioral strategies, social supports, and medication.

5. **Safety from Harm** - applies to strategies for keeping persons safe, including no contact orders, and safety plans, crisis responses, and/or safety supports. A behavioral crisis is one in which the person presents behaviors that put himself or others at risk of harm. A health crisis is one in which a chronic health condition suddenly becomes acute, putting the person's life at risk unless immediate medical care is provided. A safety crisis is a situation in which another person through intention and action or inaction puts the focus person at risk of injury or death.

6. **Income & Basic Necessities** - includes strategies for work, earned income, securing and managing benefits, obtaining housing, food stamps, housing, income maintenance, health care, medicine, or child care. Securing such supports, when they are lacking, may be necessary for the person's well-being, daily living, and for some adults, maintaining family functioning.

7. **Functional Life Skills Development** - involves skill-specific training and direct support to acquire, apply, and sustain functional life skills in daily living situations. Functional life skills include activities of daily living (ADLs). Functional skills are needed for successful everyday living and fulfilling important life roles, such as parenting dependent children or adults in the person's care.

8. **Education or Work** - includes education, career development, volunteering as a productive activity, and work, either competitive or supported.

9. **Community Integration** - for some adults, recovery includes regaining degrees of community integration. Community integration involves making decisions about choice of life activities and experiencing life activities in mainstream settings as do other adults who do not have disabilities. Aspects of community integration include engaging in normal life activities outside of an institution or provider agency that involve having interactions with non-disabled persons who are engaged in the same activities (e.g., attending a ball game, eating in a cafe, riding a public bus, voting in an election).

Desired Outcomes of Practice

SITUATION TRACKING, PLAN ADJUSTMENT, TRANSITIONING. • Situational awareness is sustained by tracking the person's life situation, changing circumstances, service process, progress, and goal attainment. • Plans are kept relevant and effective by identifying and resolving service problems, overcoming barriers, and replacing failed strategies. • Seamless and successful transitions are achieved by ensuring continuity of care across settings and providers as well as supporting the person's successful post-change life adjustments in a new setting or situation.

Key Concepts

Sustaining Situational Awareness. Ongoing situational tracking is used to: 1) monitor the person's status, service process, and progress; 2) identify emergent needs and problems; and 3) plan adjustments in services to keep strategies relevant and effective. Measuring progress toward wellness/recovery goals is an essential part of tracking and is accomplished by tracking the direction and pace of life changes made and proximity to the attainment of goals.

Keeping Plans Relevant and Effective. Effective tracking and adjustment build results-based accountability into case practice. Intervention strategies, supports, and/or services are tracked and are modified when goals are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. Working together, the care coordinator, team members, and the person play a central role in tracking and adjusting intervention strategies, services, and supports by applying knowledge gained through ongoing assessments, monitoring, and periodic evaluations.

Achieving Successful Transitions & Continuity of Care. The term *care transition* refers to movement of a person between care locations, providers, or different levels of care within the same location as the person's condition and care needs change and is a subpart of the broader concept of care coordination. Care coordination involves numerous providers who are dependent upon each other to carry out disparate activities in a person's care. In order to accomplish this in a coordinated way, each provider needs adequate knowledge about their own and others' roles and available resources, and relies on exchange of information in order to gain this knowledge. An effective discharge and care transition ensures the person and caregiver are able to understand and use essential health information they have been given and are able to move seamlessly from one service setting or provider to another. It requires the carefully planned transfer of clinical responsibility with the information needed to discharge that responsibility safely and effectively. The process requires: 1) essential clinical information at transition or discharge, 2) the opportunity to ask questions, 3) a seamless clinical envelope with a responsible clinician ("a seamless clinical envelope" means that the person is always enclosed in and surrounded by the care system, there are no lapses in care, and at all times in the transition there is an identifiable knowledgeable available clinician who is responsible for managing the person's clinical issues), 4) and logistical and management support for person and caregiver with the person's status and well-being being monitored across life adjustments throughout the transition process. Care and support are provided during the change process to ensure the person is managing the stress of the change, is stable and is functioning successfully in the new setting with adequate supports provided for ongoing success.

Practice Tips

1. Sustaining Situational Awareness. Maintaining adequate awareness and understanding of the person's status, service process, and progress are essential for effective care coordination. The identified care coordinator has a lead responsibility for sustaining situational awareness while working collaboratively with the person and others involved in the person's care. Tracking progress is accomplished by: • Monitoring the person's status, service process, and progress and by • Identifying emergent needs and problems.

2. Keeping Plans Relevant. Building upon situational awareness, the care coordinator or case manager and clinician have lead responsibilities for working collaboratively with the person and his/her team to update assessments, advance the clinical case formulation, modify goals, and refine risk management and intervention plans for provision of supports and services. Keeping plans relevant is accomplished by: • Facilitating team decision-making about next step actions and by • Planning adjustments in strategies, supports, and services to keep plans relevant and effective.

3. Achieving Successful Transitions and Continuity of Care. The person's care coordinator, clinician, and care team play a central role in planning and facilitating transition activities (including those involving discharge from one place of care and movement to another) to ensure continuity of care during a seamless transition to and successful life adjustment in a different care location. The lead clinician and care coordinator: • Provide essential clinical information at discharge and during the transition process; • Answer questions posed by the person or caregiver; • Provide wraparound care and support to prevent any lapses or breakdowns in care during and after the transition; • Provide logistical and management support for the person and caregiver during the transition; • Provide follow-along support after the transition to ensure that the person has continuity of care and achieves a successful life adjustment with sufficient ongoing supports to maintain well-being and achieve planned goals.

Desired Outcomes of Practice

SOLUTION FOCUSED BRIEF THERAPY: • The person's concerns and reasons for requesting help are clarified. • The person's aspirations and vision for a preferred future are identified. • The person develops and demonstrates motivation and confidence in finding solutions. • The person's strengths and past successes are used to build solutions. • The person is taking small steps in the right direction toward a preferred future.

Key Concepts

Solution Focused Brief Therapy (SFBT) is a recognized evidence-based practice that focuses on a person's strengths and previous successes rather than failings and problems and is provided via conversations that stimulate and support positive life change for a person receiving services. These conversations are centered on the person's concerns; who and what are important to the person; a vision of a preferred future; the person's exceptions, strengths, and resources related to the vision; scaling of the person's motivation level and confidence in finding solutions; and, ongoing scaling of the person's progress toward reaching the desired future. The goal is helping a person rapidly find a solution to a his/her identified and resolvable life problem.

Basic concepts of SFBT are:

- It is focused on the person's desired future, not the past.
- The person and provider create solutions based on what has worked in the past.
- It assumes that solution behaviors already exist and encourages the person to increase the frequency of these useful behaviors.
- It places responsibility for change on the person.
- It asserts that small steps in the right direction lead to larger changes.

Solution-Focused Questions

Solution-focused questions about the topics of conversation are used to connect to and build on the concerns and aspirations expressed by the person. Examples of solution-focused questions include:

- Given the issue or problems you are faced with, what are you hoping we can achieve together?
- How would you like your life to change in regard to the issues we have been discussing?
- Are there things you have tried already to solve this problem?
- What are some things you have already accomplished that you are pleased with?
- What types of support do you have from family/community/resources?
- What personal traits, skills, and talents have helped you in the past?
- What personal qualities are helping you get through these difficult times right now?
- How is it you found the strength and wisdom to come here for help?
- What do you suppose you do or have done so that the problem isn't any worse?
- What have you tried in the past when confronted with these types of problems?
- Would this type of solution help with your situation now?
- When you have achieved your goal, what are some things you will experience that will let you know that your goal has been accomplished?
- If your problem suddenly went away, what would be the first thing you would notice about yourself (how would be feeling, thinking, doing)?
- How would those around you know that this big change had occurred?

Desired Outcomes of Practice

MOTIVATIONAL INTERVIEWING: • The person is assisted to become increasingly aware of the potential problems caused, consequences experienced, and risks faced as a result of a particular behavior, is eventually able to envision a better future and becomes increasingly motivated to achieve it.

Key Concepts: Motivational Interviewing

Motivational interviewing is a practice that achieves success by facilitating and engaging intrinsic motivation within the person in order to change behavior. Motivational interviewing is a person-centered style of engagement for eliciting behavior change by helping a person to explore and resolve ambivalence about the desired change. It is non-judgmental, non-confrontational, non-adversarial and is based upon the concept of risk-reduction. Motivational interviewing recognizes and accepts the fact that persons who need to make behavior changes enter counseling at different levels of awareness and readiness to change.

In order for a practitioner to be successful at motivational interviewing, five basic skills will be necessary: 1) The ability to establish a therapeutic relationship through genuine empathy, warmth and respectful treatment. 2) The capacity for reflective listening. 3) The ability to ask open-ended questions. 4) The ability to provide affirmations. 5) The ability to periodically provide clarifying summary statements to the person.

The motivational practice attempts to increase the person's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question as well as helping the person to envision what might be gained through change.

The four general principles are:

1. **Express Empathy**. Empathy involves seeing the world through the person's eyes and sharing in the person's experiences. The practitioner's accurate understanding of the person's experience, which is demonstrated by reflective comments and summary understanding statements, can encourage change.

2. **Develop Discrepancy**. Practitioners help persons appreciate the value of change by exploring the discrepancy between how the person wants his or her life to be versus how it is currently (or between their deeply-held values and their day-to-day behavior). Practitioners assist the person to explore and resolve her/his ambivalence as well as grieving the need to change.

3. **Roll with Resistance**. The practitioner does not fight a person's resistance, but "rolls with it." Statements demonstrating resistance are not challenged because they are an indicator that the practitioner has “lost” the person. Instead the practitioner uses the person's "momentum" to refocus and further explore his or her views. The practitioner may need to apologize and repair the relationship if he/she has been “lecturing” the person. Using this approach, resistance tends to be decreased rather than increased, as persons are reassured that they are in charge of their own lives. Motivational interviewing encourages persons to develop their own solutions to the problems that they themselves have defined with the practitioner functioning as a partner in the process as both of them look toward the goal together.

4. **Support Self-Efficacy**. The practitioner explicitly embraces the person's autonomy (even when persons choose to not change) and helps the person move toward change successfully and with confidence. As persons are held responsible for choosing and carrying out actions to change, practitioners focus their efforts on helping people stay motivated, and supporting their sense of self-efficacy by celebrating small steps and any effort toward change.

Key Points on Motivational Interviewing are:

- Motivation to change is elicited from the person and is not imposed from outside forces.
- The practitioner's job is to help the person discover his/her own path.
- Direct persuasion is not an effective method for resolving ambivalence.
- The practitioner is generally quiet and elicits information from the person who does most of the talking.
- The practitioner helps the person to examine and resolve ambivalence and to grieve the need to change.
- The therapeutic relationship is viewed as a partnership.

APPENDIX N

Interdisciplinary Teaming in Behavioral Healthcare

Definition of Teaming

Teaming is an ongoing group-based process used for case-level learning, reasoning, and decision making. In teaming, appropriate people join together to help achieve agreed upon wellness and recovery goals for a person receiving services.

The Six-Cs of Teaming

Teaming involves ongoing group-based processes that build and sustain: *[The Six-Cs of Teaming]*

- Communication – ongoing exchange of essential information among team members (supporting an individual receiving services) that is necessary for achieving and maintaining situational awareness in case practice.
- Coordination –organization of information, strategies, resources, and participants into complex arrangements enabling team members to: work together, identify a person's needs and goals, select strategies for a course of action, assign responsibilities for action, contribute and manage resources, and track and adjust strategies and supports to achieve goals.
- Collaboration – operation of shared decision-making processes used to identify needs, set goals, formulate courses of action, implement supports and services, evaluate results.
- Consensus – negotiated agreements necessary for achieving common purpose and unity of effort among members of a person's team.
- Commitment – promises made by members of a person's team to help achieve a set of goals, related courses of action, and resources supplied by members to the same.
- Contribution – provision of time, funds, or other resources committed by the person and members of the person's team necessary to support ongoing teaming and to implement the course of action agreed to by the person and person's team members.

These six elements of teaming may be performed by using a variety of media [with the person's knowledge and consent]; e.g., texting members to update them on an emergent event; using email communications to ask or answer questions; sharing assessments, plans, and reports; conducting conference calls via telephone; using skype conferences; and, conducting face-to-face meetings with the person present when key decisions are made.

Core Concepts of Teaming

Shared Decision-Making.

Person-centered, wellness- and recovery-oriented practices, and self-directed care principles put the person's needs, aspirations, and choices at the center of service provision efforts. A team-driven, shared decision-making process helps the person create a vision for a better life based on aspirations for well-being, supports for living, improved daily functioning, and role fulfillment. Informal supporters and service providers join with the person to define wellness and recovery goals to be achieved along with related strategies for provision of supports and services. Because the efforts of many participants may be applied in helping the person, achieving *common purpose* and *unity of effort* are essential for success, creating the organizational *glue* that holds things together in practice for the benefit of the person receiving services. Teaming is most useful in complex case-practice situations.

Common Purpose.

Common purpose is created when the person and service providers involved agree upon and commit to clear goals and plan a related course of action supported with resources necessary for effective implementation. An ongoing, person-centered, shared decision-making process may be used to achieve consensus and maintain commitment to a set of well-planned goals and related strategies based on a strong sense of common purpose that drives the planned course of action.

Unity of Effort.

Unity of effort is based on achieving and maintaining:

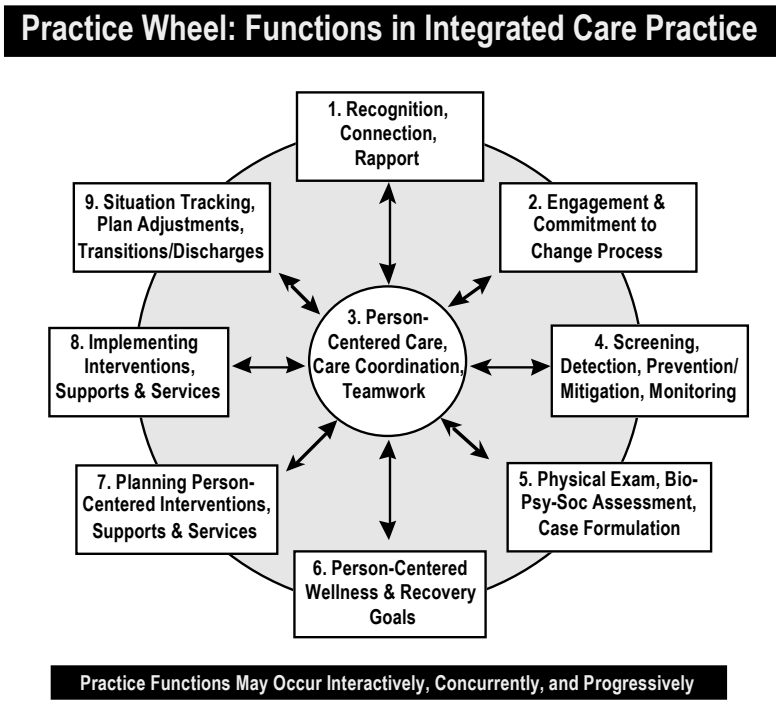
- A common understanding of the person's situation;
- A common vision for a better life experienced by the person served;
- Coordination of efforts to ensure coherency and continuity;
- Common measures of progress and ability to change course as necessary.

Unity of effort is achieved and maintained via ongoing teamwork, coordination of actions among participants, and integration of services across providers, settings, funding sources, and points in time.

Teaming is a Central Practice Function

Core practice functions are essential processes used in case practice to identify problems and unmet needs, to plan strategies and services used to solve complex problems and meet needs, and to ensure effective delivery of strategies and services in order to get desired results. The practice wheel shown below illustrates a combination and sequence of processes used in effective case practice to plan and

provide need-responsive services. *[A separate tip sheet booklet explains the practice wheel functions shown below.]*



Core practice functions include engagement, assessment and case formulation, planning goals and strategies, implementation, tracking, adjustment, and teaming. Teaming (see function 3 in the display above) provides the central learning, decision-making, and service integrating elements that weave all of practice functions together into a coherent effort for helping a person served meet needs and achieve life goals. Teaming and care coordination are logically interrelated elements.

Considerations for Teaming

Teaming Supports Shared Decision Making.

Fast moving case-level service situations in behavioral healthcare require people who know how to team, people who have the skills and flexibility to act in moments of potential collaboration when and where they appear. They must have the ability and authority to act quickly, move on, and be ready for the next such moments. Teaming relies upon old-fashioned teamwork skills such as recognizing opportunities, clarifying interdependence, building trust, and figuring out how to communicate, coordinate, and collaborate in case practice situations. There may be little time to build a foundation of familiarity through the careful sharing of personal history and prior experience or the development of shared practice experiences through working together. Instead, people must develop and use new capabilities for sharing crucial knowledge quickly. They learn to ask questions clearly, quickly, and

frequently. They act on what they learn. They make adjustments through which different skills and knowledge are woven together into timely strategies, supports, and services for the people they serve.

Teaming is an Engine for Case-Level Learning and Action.

Teaming is an engine of case-level learning and action in providing social and behavioral health services to persons having complex needs. Teaming and collaboration refer to the abilities to cooperate as a member of a successful action-focused group, to interact smoothly with others involved, to share information effectively, and to work together with one or more people to achieve a goal. Effective teams are those with clear goals, well-designed tasks that are conducive to teamwork, team members with the right skills and experiences for the task, adequate resources and time to get the job done, and access to any needed coaching and technical support.

Teaming is a Process, Not an Event.

Teaming is an ongoing problem-solving process, not a discrete event - such as holding a meeting. It is teamwork on the fly. Teaming is a dynamic activity, not a static group or structure. It is largely determined by the mindset and practices of teamwork. Teaming involves coordinating and collaborating without a prescribed or rigid team structure that would become burdensome or self-limiting over time.

Teaming Should Be Person-Centered.

From a "person-centered" point of view, case-level teaming happens only when the person whose needs and services are being discussed is actually present at the team meeting. Any meeting at which the person is absent when their needs and services are discussed is an *agency staffing*.

Team Formation: Effective Teaming Requires the Right People.

Effective case-level teamwork involves having the right people working together with and for the person being served. The team should have the technical and cultural competence, the knowledge of the person, the authority to act on behalf of funding agencies necessary to commit resources, and the ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person.

Team Functioning: Effective Teaming Supports Ongoing Collaborative Problem Solving.

Successful collaborative problem solving is a key indicator of effective team functioning. Teaming is used for:

- Understanding a person's situation (e.g., unmet needs, urgent problems, aspirations, life goals, support system) and what would have to change in order for the person to get better, do better, and stay better;

- Planning a course of action (i.e., strategies, supports, and services) for meeting the person's needs and goals;
- Solving complex problems encountered that may thwart life-change efforts and,
- Determining when needs are met, goals are achieved, and when services should be changed or concluded.

Team functioning is evaluated on the basis of the actual results achieved, rather than evaluated based on the good intentions of those involved or compliance with funding requirements.

Team Coordination: Effective Teaming Requires Leadership.

Leadership and coordination are necessary to:

- Form and convene a person-centered team and facilitate teamwork for a person receiving services;
- Plan, implement, monitor, modify, and evaluate services provided;
- Integrate strategies, activities, resources, and interventions agreed upon by the team;
- Measure and share results to determine progress and change strategies that do not work;
- Ensure a unified process involving a shared decision-making approach.

While leading and coordinating may be appropriately discharged by a variety of team members, it is most effectively accomplished by a designated and qualified leader (e.g., a care coordinator) who prepares team members, convenes and organizes meetings, facilitates team decision-making processes, and follows up on commitments made. Individual(s) filling these roles should have strong facilitation and negotiation skills, authority to convene teams and act on team decisions, and, as appropriate to role, clinical skills in assessing, planning, monitoring, and evaluation. In a case where several agencies and providers are involved, use of negotiation skills may be necessary to achieve and sustain a coordinated and effective service process. Leadership and coordination responsibilities can be shared with an empowered and capable service recipient in order to increase self-direction of care.

Effective Team Meetings Require Preparation, Facilitation, and Follow-Up.

Preparation: A team meeting may be used when making decisions that could alter a person's life or make a major change in service arrangements. Basic considerations for team meeting preparation include making sure that the:

1. Person and other participants understand the purposes of the meeting and the issues to be addressed sufficiently prior to the meeting to allow time for participants to organize thoughts and materials necessary.
2. Participants are ready, able, and available for team participation.
3. The right people are invited to the meeting:
    a. People necessary for the major decisions to be made.

    b. People invited by the person for their own support.
    c. People invited by the agency for service provision.
4. Participants know the purpose of the meeting and how to contribute in a positive way:
    a. Come prepared and ready for decision making.
    b. Speak to their concerns in constructive ways.
    c. Listen with respect to others' concerns.
    d. Recognize and build on the person's strengths and needs.
    e. Share information, ideas, and resources.
    f. Keep personal and confidential information private.
5. Participants know what to bring to be prepared as well as when and where to meet.
6. Logistical arrangements are made:
    a. Meeting place and time should be mutually convenient for the person and other participants.
    b. Meeting place should be conducive for private and confidential conversations.
    c. Refreshments and restrooms should be available for participant comfort.
    d. The agenda should include the person's statement to begin or end the meeting.
7. The facilitator is prepared to accomplish the primary purposes of the meeting.
8. The facilitator and agency staff are prepared to follow-up on decisions made and on next step plans.

Making important decisions and the related next step plans for implementing those decisions should be the basis for a team meeting agenda.

Facilitation. Team meetings are facilitated by a person who has completed an approved meeting facilitator training program and who is competent to facilitate meetings that focus on wellness and recovery. Any relevant cultural issues of the person are recognized and accommodated before, during, and after the meeting. A qualified facilitator:

1. Convenes the meeting, defines the goals and ground rules of the meeting, introduces participants and their roles, defines decisions to be made and the possible range of actions to follow the decisions.
2. Uses consensus-building decision-making techniques, handles any conflict as it surfaces, selects appropriate idea-building processes, solicits all view-points, clarifies options, refocuses as necessary to stay on task and on time, monitors and manages the flow of discussion to ensure that all are heard and no one dominates, brings discussions to closure with decisions made, and moves on to next steps, assignments, and commitments. This is done by:
    a. Sharing inspiring visions to guide decisions and plans.
    b. Focusing on results, processes, and relationships.

    c. Designing pathways to action for realizing opportunities, building capacities, and solving problems.
    d. Seeking maximum, appropriate involvement in decisions.
    e. Facilitating the group to build agreements and meet challenges. [What could go wrong with this plan?]
    f. Coaching others to do their best.
    g. Confronting problems honestly and respectfully.
    h. Managing power and control issues that arise.
    i. Balancing person-centered practice with any court-ordered requirements.
    j. Celebrating successes and accomplishments.
3. Builds an understanding of assessment results, the person's aspirations and challenges, court requirements, and programmatic or funding requirements:
    a. The person's story, strengths and needs, risks, barriers to change, and desires to improve.
    b. Requirements for behavior change by external sources -- the court, school, or family.
    c. Changes the person must make plus their potential, motivation, and progress as it is being made (prognosis).
4. Summarizes decisions, clarifies goals, and secures commitments.
5. Sets goals for change, selects change strategies, plans interventions and support with the person and the person's supporters.
6. Secures commitments from participants for plans made.

Service Planning and Follow-Up. Case-level team meetings serve as vehicle for service planning, coordination, communication, and accountability. The person's team develops, monitors, and evaluates an individualized, strengths-based, needs-driven service plan that responds to the person's strengths, needs, goals, and preferences identified in the assessment. Via the planning process, the team may help the person develop and use a network of informal supports that can help sustain the person over time. The person's team develops, monitors, and evaluates any individualized child service plans for a child or youth with special needs.

Challenges that May Thwart or Disrupt Effective Teaming

A powerful and continuing set of factors presently operate in state services that effectively prevent or discourage effective teaming. Among these factors are:

- Service siloes (i.e., programmatic structures) created by state and provider agencies that lack boundary-spanning authority for use of cross-agency service coordinators to support teaming for persons receiving services from multiple programs and funding sources;

- Funding constraints that limit reimbursements for team member participation;
- Need for qualified team facilitators having the skills necessary for effective team preparation, facilitation, and follow-up;
- Care coordinators lacking the authority to convene and facilitate teams as well as lack of sufficient time to facilitate teaming activities due to excessive caseload assigned.
- Lack of role definitions (concerning who does and pays what) and support for team members from multiple agencies serving the same person.
- Concerns about personal, professional, and agency liability for shared information and group-based decisions in a litigious service environment.
- Differences in organizational cultures and languages used in multi-disciplinary settings and teaming situations may lead to confusion and conflict in teaming situations.
- Perceived power differentials between potential team members (e.g., physician, community support coordinator, peer support provider) and their time availabilities for teaming processes seen as disruptive to teaming.

These are persistent factors that undermine local agency efforts to provide effective teaming for persons having complex service needs.

APPENDIX O

Minimum Standards for Family Team Decision Making

Introduction

Family Team Decision Making (FTDM) is both a philosophy and practice strategy for delivering child welfare services. The Department of Human Services [DHS] child welfare focus is on serving families with children at serious risk of harm from abuse and neglect. Building teams at the time of crisis to support families where there is a risk of serious harm to the child has been identified as a means to address the factors that threaten the child's safety, establish permanency for the child, and promote well being – central expectations in the provision of child welfare services.

FTDM can be used to enhance the core casework functions of family engagement, assessment, service planning, monitoring and coordination. When properly applied, FTDM supports a trust-based relationship, facilitates family engagement, and sustains the family's interest and involvement in a change process. Within the context of practice, family team meetings allow for regular monitoring of the case plan, ongoing evaluation of what is working and what is not working so that intervention strategies can be changed or modified as circumstances change.

FTDM promotes unity of effort and provides an opportunity for all helping professionals to develop a shared understanding of the family's situation – which are critical elements in attaining positive results. FTDM should be a proportional response to the needs of the child and family that is coordinated across systems involved with the family. DHS should join with other professionals in the community who may already be conducting good family meetings.

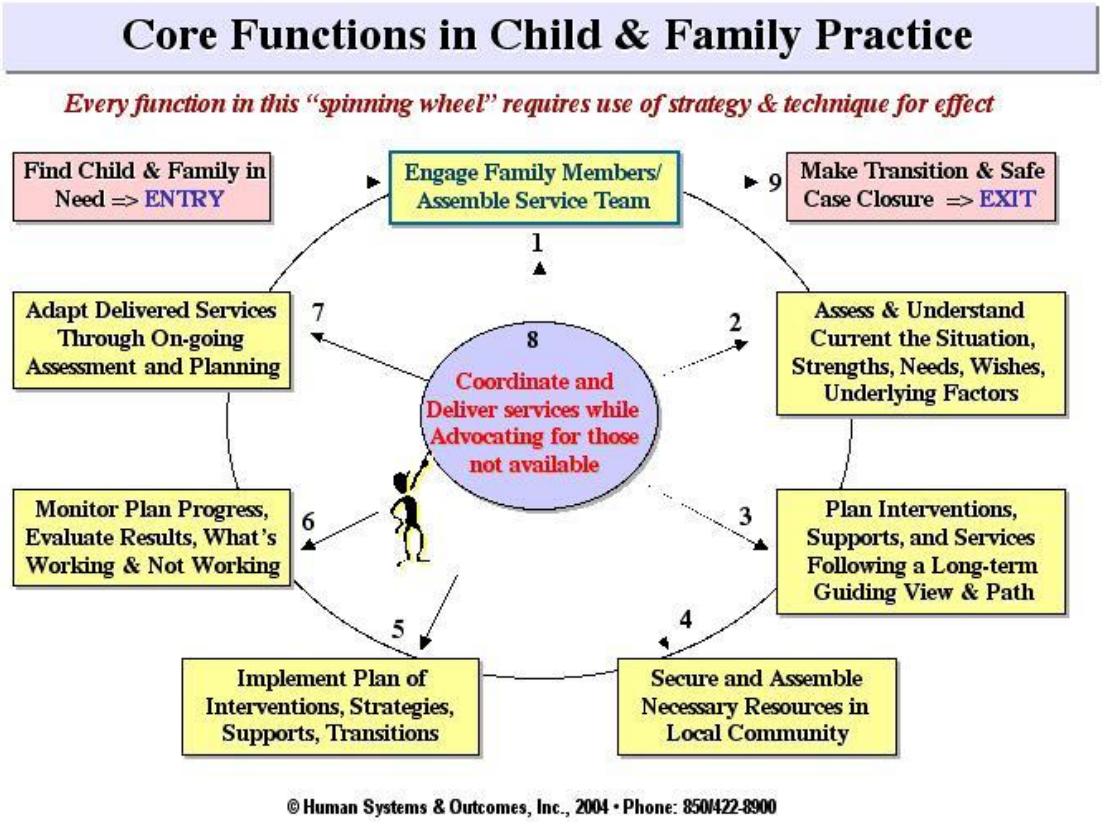
In order to achieve positive results associated with Family Team Decision Making, DHS is developing this set of standards to be used for Family Team Decision Making. Implementation will phase in this practice with a segment of cases with the goal of offering every family the opportunity to participate in family team decision-making. Iowa has developed policy that

allows flexibility in the practice of family team decision-making. As a result, a rich variety of family team meeting models are being utilized.

Both the *Better Results for Kids* redesign and the *CFSR PIP* place an emphasis on family team meetings as a critical practice change strategy.

Context for Family Team Meetings

It is important to recognize that FTDM is not a linear process of engagement, assessment, planning, and implementation. Rather it is a cyclical and dynamic process, which should grow and change over the life of a case. The following graphic defines typical case activities that are expected components of front-line practice.



Each core function is supported in the family team decision making process. In conducting a family team meeting:

- the family is further engaged [Step 1] through the facilitation of a meeting where the family's opinions are respectfully considered and their natural support system is included;
- the family team which includes informal as well as formal support persons provide further assessment and understanding [Step 2] of the family and their circumstances as strengths, needs, and underlying factors are considered and discussed;
- as the family plan [Steps 3, 4 & 5] is developed by the team, interventions, supports, and services are planned, resources are considered, and implementation of the plan begins;
- as the family team is reconvened to monitor progress [[Step 6], further assessment of what's working or not working is conducted, and services are adapted or changed; [Step 7] or, when planning for transition and safe case closure [Step 9].

Values and beliefs that help guide family teams include:

- Families have strengths and protective capacities.
- Families are experts on themselves and their situation.
- Families deserve to be treated with dignity and respect.
- Families can make well-informed decisions about keeping their children safe when they are supported in doing so.
- Families involved in decision-making and case planning are likely to have better outcomes than families who have decisions made for them.
- Families and friends can provide love and caring in a way that no formal helping system can.
- Families are capable of change. Most people are able to find solutions within themselves, especially when they are helped in a caring way to find that solution.
- A family team is more capable of high-quality decision-making that an individual caseworker acting alone.
- Solutions generated by the family within a team meeting are more likely to succeed because these solutions respond to the family's unique strengths, needs, and preferences.
- Cultural competence is key to understanding the family and the choices they make about change.

The following minimum standards are intended to guide daily practice in the use of FTDM.

FAMILY TEAM DECISION MAKING STANDARDS

Standard 1. Careful preparation of all participants is required for successful family team decision-making.

The initial phase of FTDM prepares the family to understand their role and to participate as decision makers in the process. Professionals and other team members should also be provided with an orientation to clarify their role and help them make a positive contribution.

The preparation phase can be used to initiate engagement and assessment activities and establish a climate of safety for the family. It is important that all participants are prepared for the family team meeting, agree to what will be accomplished, and understand the purpose of the meeting.

Successful preparation includes helping participants

- Set a positive, honest tone with a focus on strengths as well as needs
- Plan how they can manage emotions positively and contribute to the team

Standard 2. The Family is engaged throughout the family team decision-making process.

Family engagement is the ongoing process of developing and maintaining a mutually beneficial, trust-based relationship that empowers and respects the family and sustains their interest and participation in a necessary and time-limited change process. Diligent effort is made to join with the family and the family's natural supports to insure that needs are met and child safety and well-being are assured. Successful and productive relationships with families are earned over time through repeated, positive contacts that develop trust.

Successful family engagement strategies include the following:

- Approach the family from a position of respect, cooperation, and shared decision making.

- Engage the family around a shared concern for the safety of the child and well being of the family.
- Explain the agency's concern and reason for involvement clearly, directly, and honestly.
- Discuss issues of maltreatment (i.e., needs, conditions, and behaviors interfering with safety and well-being), consequences, timelines and the Department's ongoing responsibilities.
- Help the family achieve a clear understanding of the safety and risk issues for the child.
- Empower the family to identify and define what it can do for itself and where the family or individual members need help.
- Focus on family strengths (e.g., culture, traditions, values, and lifestyles) as building blocks for services and family needs as a catalyst for service delivery.
- Assist the family to develop natural supports that will enhance the family's capacity and build a circle of support that will see the family through difficult times.

The 'art' of practice within FTDM is a careful balance that includes a demonstrated respect for the family, the expectation that change will occur, and overseeing accountability for that change.

Standard 3. Relevant cultural issues of the child and family are identified and accommodated through adjustments in strategies, services and supports for the family in the family team decision making process.

Successful cultural competence includes:

- A basic understanding of the values and beliefs within the culture coupled with eliciting information from the child and family about traditions, cultural beliefs, behaviors, and functioning
- Demonstration of values and attitudes that promote mutual respect
- Communication styles that show sensitivity
- Accommodations in the physical environment including settings, materials, and resources that are culturally and linguistically responsive

The facilitator of a family team meeting should possess a reasonable level of competence and understanding of the culture in which the family has gained its understanding of child rearing practices. Families who speak languages other than English may require greater preparation in advance of meetings and cultural accommodations - such as the use of interpreters or co-facilitators who speak the language – to insure their full participation in a family team meeting.

Standard 4. Family teams include the family, supporters identified by the family, and others who sponsor or deliver plans of intervention for the family or any of its members.

A family team should include those persons who collectively possess knowledge of the family, have the technical skills necessary to engage the family in a change process, and who have access to resources and the authority necessary to provide effective services for the child and family. The child and family's role as team members is foundational.

For a family team meeting to be successful the child, the family, its informal supports, and all involved helping professionals must be viewed as full, participating team members. By having all services and supports present at team meetings, all contributors are aware of and in agreement with the plan, understand their role and how it relates to that of other contributors, and know what others expect of them. This mutual understanding helps to assure unity of effort and improves the effectiveness of team functioning. All team members should be present whenever major decisions are made. Periodic assessment of the team composition should be made to determine if the composition is adequate to meet the planning and resource needs of the family.

Accommodations should be made to meet the special needs of the child or family through the team formation. Examples of such circumstances include cases where the family does not speak English or is not part of the majority culture; situations involving sexual abuse, or domestic violence. Additional team members may be needed to provide support to a child or to help team members manage behaviors and make a positive contribution. When special circumstances exist it may be necessary to involve an individual who has specialized knowledge and skills (e.g. in

the area of domestic violence, or an individual who is a member of the family's culture or ethnic group) as a team member, co-facilitator, or as a support person for a team member.

Family dynamics or special circumstances may preclude the formation of a 'typical' family team. Examples of such circumstances may be court restraining orders; situations where a family team meeting would place the child or other team members in danger or significantly inhibit attainment of the child's permanency goal.

Standard 5. Family team meetings are facilitated by a person who has completed the DHS approved FTDM facilitator training and competent to conduct meetings that focus on child safety, permanency, and well being.

The facilitator may be a DHS staff member, case manager or supervisor, provider staff, community partnership staff, family support staff or others trained to facilitate family team meetings. Efforts must be made to maintain continuity of the facilitator in successive meetings.

It is important to select the most appropriate and effective facilitator for the family based on the presenting circumstances. The family members should participate in identification of the facilitator.

The competency of a facilitator is determined by demonstrated knowledge and skills. At a minimum, facilitators are approved by DHS when they have:

- Completed DHS approved Facilitator Training [minimum 18 hours],
- Completed a family team meeting as co-facilitator with an approved facilitator who has provided coaching and mentoring feedback; and
- Completed a family team meeting as lead-facilitator with an approved facilitator who has provided coaching and mentoring feedback.

Central Office will maintain a list of approved curriculums. The local DHS office will provide approval and maintain a list of approved facilitators. To be approved, experienced facilitators

and current practitioners must provide documentation of equivalent training and experience to the local office within six months of this standard going into effect.

Standard 6. Family team meetings are conducted at a mutually agreeable and accessible location that maximizes opportunities for family participation

First and foremost the family needs to be consulted and actively participate in the choice of the location. In some cases it is necessary to balance the preference of the family with the resources in your community and with the need to include a provider or other important contributor in a family team meeting.

This standard requires determination, with the family, of the best time, date, and place for convening the meeting. It also requires determination of what the family needs to fully participate in the family team meeting, such as transportation, childcare, a reminder call, an interpreter, a peer advocate or other related supports. The best place to hold a family team meeting is the most neutral, comfortable setting possible. The most important considerations for a meeting setting are the assurance of privacy, security and a place without interruptions.

Standard 7. The focus of Family Team meetings is case planning, coordination, communication, and accountability.

The focus of family team meetings is to enhance the core casework processes of family engagement, communication, functional assessment, service planning, monitoring, evaluation of results, and provide input into key decisions affecting child safety, permanency, well being, and sustainable family changes.

Family teams are formed, convened, and function to produce the family plan and/or the case permanency plan. Family teams are reconvened throughout the duration of the department's involvement with the family. The team needs to identify the conditions for safe case closure and plan for it early in the process.

Family team meetings provide an opportunity to regularly assess and monitor the effectiveness of services and interventions. If services or interventions are found to be unsuccessful – or unresponsive - the family team has an opportunity to modify the plan to meet the family's changing needs. When progress is slow or the prognosis for reunification is declining, the family team can play an important role in helping families understand, accept, and participate in concurrent planning and the necessary permanency decisions.

The above strategies can help to build accountability while maintaining a balance between family-centered practice and the necessary protective authority of DHS in ensuring child safety, permanency, and well-being.

It should be noted that the family and age-appropriate child(ren) have the right to refuse services, unless refusal of services places the child in danger. While services may not always be delivered as requested by the family, services are to be delivered in a manner that reflects partnership between DHS and the family. When the family and child refuse or do not access services as agreed upon, the caseworker should assess the reasons for refusal and the team should consider new or modified services. If the family's decision to refuse or not use services places the child in danger, the caseworker should notify the court.

Examples of when family team meeting occur include whenever protective or permanency decisions or plans are being made:

- The family requests a meeting.
- The family plan is being developed or changed.
- Progress is slow or the prognosis for reunification indicates a need for concurrent planning.
- Within 72-96 hours of a child's voluntary or involuntary removal from the home for an emergency placement.
- Placement changes or permanency decisions are made, e.g. reunification, transition from foster care to adulthood, termination of parental rights.
- Before safe case closure to plan for sustainability.

<u>Standard 8.</u> Team members keep personal and private details of the family discussed in a

team meeting private.

All team members sign a confidentiality agreement before conducting team meetings and the facilitator explains the importance of privacy. Ensuring privacy and confidentiality is necessary for building family trust and demonstrating respect for the family. Trust is enhanced by informing all team members of the following exceptions to maintaining confidentially which must be reported and are mandated by law:

- New allegations of suspected child abuse/neglect,
- A belief that the individual intends to harm himself or
- A belief that a person intends to bring harm to others.

Standard 9. The team assists the family to develop and use a network of informal supports that can help sustain the family over time.

If used effectively, informal supports can help sustain positive change for a family over time and permit the formal system to transition out of the family's life. These supports can also help the family deal with future challenges without the need for system intervention. The team helps the family identify, develop, and sustain informal supports. The process of recruiting and maintaining informal supports begins at the case onset, is ongoing, and should be reassessed periodically by the team.

Standard 10: The effectiveness of each family team meeting is assessed and adjustments are made to improve the ongoing process and the results for families.

Ongoing assessment of the effectiveness of family team meetings for engaging families, conducting assessment and planning activities and determining service interventions is part of ongoing practice. When problems are discovered, adjustments and adaptations should be made when needed to improve the process and results.

The indicators of family team meeting effectiveness include the following:

- Degree of engagement and sustained interest in working toward change shown by the family.
- Degree of involvement of family team members in the evaluation process and constructive use of the information gained.
- Effectiveness of the circle of support assembled for the family in addressing family issues.
- Satisfaction of team members with the process and results achieved to date.
- Quality and effectiveness of the family service plan produced in the family team meetings.
- Demonstrated degree of family acceptance of the service plan.
- Capacity for ongoing problem solving by the family.
- Degree to which the family plan was achieved.

APPENDIX P

Highlights of the first 4 encounters in the Treat First Clinical Model

1st visit: The first visit focuses only on the person's request for help, clarifying the concern, and beginning a solution-focused intervention process. A therapist would be the first point of contact if a presenting problem is psycho-social in nature, including relationship difficulties. A Community Support Worker (i.e., CSW/ CPSW) may be the first point of contact if the identified problem is social, functional, or involves basic human needs or linkage to community resources.

Registration: The client completes registration materials before meeting with a therapist or CSW. Basic one or two question screens can be included in the registration materials relative to substance use disorder, depression, risk and crisis, and trauma. The materials may include a section for the person to list medications and a Community Engagement Checklist indicating current or historical linkages to community resources, identification of a Primary Care Physician (PCP), or other providers. This should allow the therapist or CSW/CPSW to have a quick sense about the status of the individual so to be fully engaged and present with the person rather than consumed with paperwork.

Self Check-In & Session Check-Out: A Self check-in is conducted with the person at the beginning and a Session Check-Out the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning of the session, and how useful and beneficial the session has been in making progress towards achieving the person's desired future. There are four specific questions for both check-in's.

Information Gathering. While the first visit is focused on developing a therapeutic alliance and building trust to first address urgent needs, it should also be a time to initiate the gathering of information. This includes information necessary to complete a Diagnostic Evaluation at the conclusion of the fourth visit.

Screening and Assessment: If there are significantly alarming indicators in the responses provided in the registration process, more in-depth screening may be necessary. Besides the information gathered in the registration process a therapist should complete a Mini-Mental Status Exam (MMSE) as an important part of the first visit and determine a provisional
diagnosis.

If the person is in an immediate crisis, that must be addressed before moving on to any other portion of the visit.

2nd visit: During the second visit, additional historical data are gathered. The focus is placed on medical and behavioral health history, extended support systems, identification of strengths and barriers to treatment, and other issues specifically related to presenting problem

3rd visit: Therapeutic services provided during a third visit are framed by a substantially sound understanding of the person's diagnostic situation, functional status, and evolving clinical case formulation. Additional targeted data (following local assessment and treatment planning templates) are systematically gathered to flesh-out a shared understanding by the person and provider on how to effectively address the issues raised by the person and to plan a treatment schedule for the remainder of the episode to resolve the issues.

4th visit: By the end of the fourth visit, a broader array of clinical practice functions will have begun unfolding. Early and ongoing clinical practice functions progressively come into action over time the course of the first four sessions of the Treat First Approach.

A TREAT FIRST APPROACH:

ENSURING A TIMELY, EFFECTIVE RESPONSE TO A PERSON'S NEED WHILE ENGAGEMENT, SCREENING, ASSESSMENT, AND PLANNING PROCESSES UNFOLD

PURPOSE OF THIS DOCUMENT

This document provides an overview of a Treat First Approach and describes service elements and activities associated with the first four visits or sessions provided to a person requesting services. It is intended to provide guidance for practitioners who are implementing the practice concepts and steps during a formative testing phase.

BENEFIT OF A TREAT FIRST APPROACH

Approximately 20% of all consumers will believe that their issue is adequately resolved after one visit and will not return for a second visit for positive reasons. Currently, no-show rates in many sites are between 40-60% and are usually because of the client's need (i.e., their reason for requesting services) was not addressed at the first visit. The Treat First Approach corrects the problem of delay by emphasizing the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a quick response for any urgent matters when a new person presents with a problem and requests help from the agency:

Use of a Treat First Approach overcomes historic difficulties encountered by a person requesting services of having to wait for help until many required data collection tasks are completed before getting help. Delays discourage some persons from returning for a second visit. Ensuring a timely and effective response to a person's request for services is a first priority in the Treat First Approach. This strategy provides a way to achieve immediate formation of a therapeutic relationship and initiation of a response to the person's concern while gathering needed historical, assessment and treatment planning information over the course of a small number of sessions or visits.

BASIC DESIGN OF A TREAT FIRST APPROACH

Making the most of the initial contact with a person seeking help is recognized as a key to successful engagement and quick results that benefit the person. The Treat First Approach begins with a quick screening, rapid engagement, and short intervention approach in which the reason that a person requests assistance may be addressed or resolved within the span of one to three sessions or visits.

A segment of the population of persons requesting behavioral health services may be served successfully using a short intervention approach. For others who may require longer, more extensive, or specialized interventions, the early steps in the Treat First Approach would enable the service provider to gather sufficient assessment information in order to develop a clinical case formulation and comprehensive service plan by the fourth visit. The concepts, principles, and processes used in the Treat First Approach provide a responsive way of initiating a service process for a person requesting help. Brief intervention techniques such as a Treat First Approach are part of a full continuum of behavioral health care services provided in Certified Community Behavioral Health Centers, Medicaid Health Homes, and other community-based services.

A Treat First Approach provides a useful way of engaging and assisting new persons requesting help from a service provider by providing a quick response to their concerns. Using a Treat First Approach requires that practitioners engaging with the person quickly scan (screen) the person's situation to determine if any presenting factors may constitute a threat of harm to the person or to someone in the person's life. If so, necessary steps are quickly taken to keep people safe or healthy. Thus, the Treat First Approach is used as a non-crisis model. In an identified crisis situation, the practitioner follows the local crisis protocol.

Another quick discernment made by the practitioner involves the prospect that a person's request for help could be resolved within one to three sessions or visits. Some life issues (e.g., coping with the break-up of a relationship or a job loss) may be amenable to resolution with a short intervention. Other life circumstances (e.g., multiple problems, acute psychoses, cognitive inability to focus, severe substance abuse, long history of relapse, low level of social support) for which a person is requesting help may require more intensive and sustained efforts and supports.

Thus, a practitioner should quickly understand the range and severity of presenting problems and the type of services that may be necessary to meet needs and solve problems. Doing so may require conducting additional assessments, using any necessary protective strategies, gathering of collateral information, or involvement of others supporting the person may be determined and accomplished.

Strengthening Clinical Practice

Strengthening clinical practice is a goal when implementing the the Treat First Approach. Practitioners employ core practice functions and clinical activities to join with a person receiving services to support a positive life change process that helps the person get better, do better, and stay better.

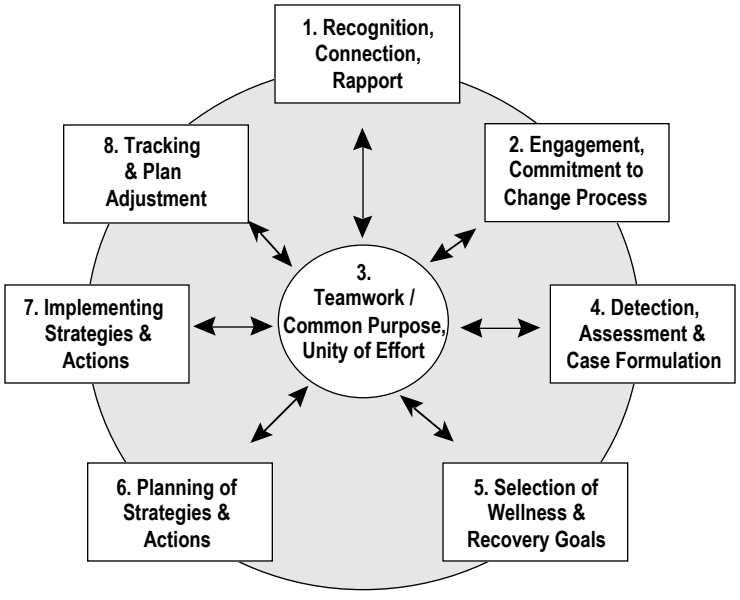
Typical practice functions include: connecting with a person based on a recognition of the person's identity and situation; detecting and responding to any urgent problems; building positive rapport and a trust-based working relationship; engaging the person in a positive life-change process; understanding the person's strengths, needs, and preferences; defining wellness and recovery goals to be achieved; building common purpose and unifying efforts though teamwork (when longer-term services are indicated); planning intervention strategies, supports, and services; implementing plans; and tracking and adjusting strategies until desired outcomes are achieved. The diagram shown below provides a framework of core practice functions typically encouraged by service providing agencies.

The diagram illustrates early and ongoing clinical practice functions that progressively come into action over the course of the first four sessions of the Treat First Approach. Tip Sheets are provided in the *Addenda* for the practice functions used in first order actions of a Treat First Approach. Tip Sheets cover the following suggested core practices and clinical techniques:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Assessment and formulation
- Wellness and recovery goals
- Teamwork - common purpose and unity of effort
- Solution focused brief therapy
- Motivational interviewing

Tip Sheets are provided to promote and strengthen clinical practice.

Basic Functions Supporting Clinical Practice



Practice Functions May Occur Interactively, Concurrently, and Progressively

Visit 1

Visit 1 Goals and Activities: General Guidance

Overview

The first visit focuses only on the person's request for help, clarifying the concern, and beginning a solution-focused intervention process. The conversation should center on the following areas:

- Who and what are important to the person;
- The person's vision of a preferred future;
- The person's exceptions, strengths, and resources related to the vision;
- Scaling of the person's motivation level and confidence in finding solutions;
- Person's expectations in seeking help;
- Ongoing scaling of the person's progress toward reaching the desired future.

Treat First Practitioners

A therapist would be the first point of contact if a presenting problem is psycho-social in nature, including relationship difficulties. A Community Support Worker (i.e., CSW/CPSW) may be the first point of contact if the identified problem is social, functional, or involves basic human needs or linkage to community resources.

Visit 1 Goal

The goal of the first visit is to gain a full understanding of the presenting problem and the impact of that problem on the person's life. This is done using relationship building skills for Recognition, Connection, and Rapport to build on the person's understanding of his/her concern or situation and what the person wants to be different in the future. The foundational elements of Treat First Clinical Practice applied in the first visit are:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Brief and solution-focused interventions

Activities & Expectations

Registration. The client completes registration materials before meeting with a therapist or CSW. Basic one or two question screens can be included in the registration materials relative to substance use disorder, depression, risk and crisis, and trauma. The materials may include a section for the person to list medications and a Community Engagement Checklist indicating current or historical linkages to community resources, identification of a Primary Care Physician (PCP), or other providers. This should allow the therapist or CSW/CPSW to have a quick sense about the status of the individual so to be fully engaged and present with the person rather than consumed with paperwork.

Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning of the session, and how useful and beneficial the session has been in making progress towards achieving the person's desired future. There are four specific questions for both check-in's. If the person is in an immediate crisis that must be addressed before moving on to any other portion of the visit.

Information Gathering. While the first visit is focused on developing a therapeutic alliance and building trust to first address urgent needs, it should also be a time to initiate the gathering of information. This includes information necessary to complete a Diagnostic Evaluation at the conclusion of the fourth visit.

Screening & Assessment. If there are significantly alarming indicators in the responses provided in the registration process, more in-depth screening may be necessary. It is important to ensure the person's safety and that the person understands the boundaries of scope of practice of the practitioner so to set appropriate expectations. Besides the information gathered in the registration process a therapist should complete a Mini-Mental Status Exam (MMSE) as an important part of the first visit and determine a provisional diagnosis. A full MSE (Mental Status Exam) may be necessary pending registration information.

Next Visit & Follow-Up

A second visit is scheduled for the following week and before the person leaves, if warranted.

Recommendations & Tips

- Using Solution Focused Brief Therapy (SFBT) concepts - See the Tip Sheet in the Addendum.
- Check-in questions and rating scales can be found in the *Addenda*.

Visit 2

Visit 2 Goals and Activities: General Guidance

OVERVIEW

During the second visit, additional historical data are gathered. The focus is placed on medical and behavioral health history, extended support systems, identification of strengths and barriers to treatment, and other issues specifically related to presenting problem(s).

TREAT FIRST PRACTITIONERS

Formative information for developing a clinical case formulation may be assembled, and the beginnings of a treatment or comprehensive service plan are noted.

VISIT 2 GOAL

The service provider discusses with the person the probable number of visits needed to resolve this particular episode of care. If it becomes apparent that the person has a newly identified condition (e.g., SMI or SED) that requires complex rehabilitation services, up to and including psychiatric medication, then a more formal approach to assessment, case formulation, and planning will be initiated.

Foundational elements of clinical practice that may be used or added during the second visit include:

- Recognition, connection and rapport
- Engagement and commitment
- Detection and quick response
- Motivational, brief and solution focused intervention
- Assessment and formulation
- Wellness and recovery goals

These basic practice elements are initiated in visit 1 and continue as indicated over successive visits as practice unfolds to assist the person requesting help. Tip Sheets explaining these elements of practice are provided in the *Addenda* of this document.

ACTIVITIES & EXPECTATIONS

Self & Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning and end of a session. A Self Check-in at the beginning shows how well he/she is doing and what has changed since the last session. At the end of the session a Session Check-in is conducted with the person by the practitioner on how useful and beneficial the session has been in making progress towards achieving the person's desired goals.

Information Gathering. Information for developing a clinical case formulation is being gathered and assembled. With a focus on behavioral health, medical history, strengths and barriers to treatment, extended support systems and other issues related to goals/problem. The provisional diagnosis is further explored utilizing a more formal approach to assessment through various techniques, strategies and diagnostic review tools.

Treatment Planning. Elements of a treatment plan are beginning to develop. Initial wellness and recovery goals are explored. The service provider and the person discuss the possible number of visits that may be necessary to resolve current and/or future goals or problems.

NEXT VISIT & FOLLOW-UP

A third visit is scheduled before the person leaves, if necessary for resolution of the reason that the person is requesting help.

RECOMMENDATIONS & TIPS

Building on the prior functions it is anticipated that from 50 to 65% of all needed data for a diagnostic evaluation, treatment plan (including complete crisis plan if needed), and modified diagnostic review should be available following the completion of the second therapeutic visit.

- Daily Living Activities- Functional Assessment (DLA-20)
- Functional Skills Evaluation
- Motivational Enhancement
- Brief Solution Focused Techniques/Strategies
- How to interpret self/session check-ins

Visit 3

Visit 3 Goals and Activities: General Guidance

Overview

Therapeutic services provided during a third visit are framed by a substantially sound understanding of the person's diagnostic situation, functional status, and evolving clinical case formulation. Additional targeted data (following local assessment and treatment planning templates) are systematically gathered to flesh-out a shared understanding by the person and provider on how to effectively address the issues raised by the person and to plan a treatment schedule for the remainder of the episode to resolve the issues.

Treat First Practitioners

If concurrent completion of the diagnostic evaluation is possible, then the therapist (not the CSW) should complete it and coordinate the completion of the treatment plan (which may involve more than one direct service provider by now) separately from a visit.

Visit 3 Goal

Where possible, data gathering for a complete diagnostic evaluation can be completed in this visit, but therapeutic concerns must be the priority. The new critical element - introduced in Visit 3 is Teamwork - common purpose and unity of effort. If completion of the diagnostic evaluation is not possible the person may be invited back for additional visits with the fourth visit ensuring a mutual agreement between the therapist and consumer on the detail in a diagnostic evaluation and the sharing of a completed written treatment plan with the person. This third visit could be billed as either a diagnostic evaluation or as an individual therapy visit.

The foundational elements of clinical practice that may be used or added during the third visit include:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Assessment and formulation
- Wellness and recovery goals
- Teamwork - common purpose and unity of effort
- Solution focused brief therapy

These basic practice elements are initiated in Visit 1 and continue as indicated over successive visits as practice unfolds to assist the person requesting help.

Activities & Expectations

In summary, these are the activities expected to occur during the third visit:

- A Self Check-In is conducted with the person to assess how well he/she is doing at the beginning of the session and what has changed since the last session.
- Services delivered are based on understanding the person's diagnostic situation, functional status and evolving clinical case formulation. The clinical case formulation evolves over time as more knowledge is gained.
- Additional data are gathered to build a shared understanding by client and therapist on how to effectively address issues raised by the client.
- Determination made about what else may be required to resolve this episode of care.
- Need for more visits are discussed along with goals and any new goals to be met.
- Based on goals selected, more specific and detailed treatment plans are developed.
- A treatment schedule is planned to resolve any remaining ongoing issues.
- A Session Check-In is conducted with the person. Rating scale results are used by the practitioner to evaluate the person's perspective on how useful and beneficial the session has been in making progress.

Next Visit & Follow-Up

The likelihood of a fourth visit is largely dependent on the degree to which the person and therapist/CSW have established the person's identified goals and desired outcomes along with a positive therapeutic relationship.

Recommendations & Tips

Tips sheets explaining these elements of practice are provided in the *Addenda* to this document.

Visit 4

Visit 4 Goals and Activities: General Guidance

OVERVIEW

By the fourth visit, some of a person's issues may have been resolved in earlier sessions while other remaining concerns may require further efforts to address. The likelihood of reaching a fourth visit may depend in part on the degree to which the person and therapist/CSW have identified further goals, achieved progress to some goals, and formed a positive therapeutic relationship. It is expected that the service provider will have a complete and clinically defensible diagnostic evaluation and treatment plan by or upon completion of the fourth visit in any episode of care.

TREAT FIRST PRACTITIONERS

By this fourth visit for persons having serious diagnosis and/or experiencing complex life situations, additional sessions or ongoing services may be required to address their needs. The treatment team may now consist of not only a therapist and CSW, but other treatment providers such as a Psychiatrist, a Nurse, and Peer Support Specialist and so on may now be part of the person's treatment team.

VISIT 4 GOAL

By the end of the fourth visit, a broader array of clinical practice functions will have begun unfolding. Early and ongoing clinical practice functions progressively come into action over time the course of the first four sessions. Tip Sheets are provided in the *Addenda* for the practice functions that are applied in first order actions of a Treat First Approach.

ACTIVITIES & EXPECTATIONS

Self & Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning and end of a session. A Self Check-in at the beginning shows how well he/she is doing and what has changed since the last session. At the end of the session a Session Check-in is conducted with the person by the practitioner on how useful and beneficial the session has been in making progress towards achieving the person's desired goals.

Accomplishments by Visit 4. By conclusion of a fourth visit, the following items will be completed by the provider:

- Screenings, evaluations, and assessments that provide a sufficient bio-psycho-social understanding of the person's situation (e.g., reasons for requesting assistance, aspirations for wellness/recovery, preferences, risks of harm, and any significant unmet needs) to develop a useful clinical case formulation and course of action.
- Clinical case formulation including a clinical history and concise summary of the bio-psycho-social factors contributing to the present disorder. It focuses on clinically significant distress and impairment in functioning experienced by the person. The case formulation considers the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern.
- Final Diagnosis: based on a full Clinical Formulation
- Wellness and recovery goals to guide a course of action.
- Comprehensive treatment plan to define a course of action for meeting the person's wellness and recovery goals.

Functional understandings and clinical case formulation have been used to guide development of a comprehensive treatment plan, including support plans where indicated, informed by the person's life stage, culture, social context, and preferences.

CONTINUATION INTO ONGOING SERVICES

For persons having serious diagnoses and/or experiencing complex life situations, additional sessions or ongoing services may be required to address their needs.

A Treat First Approach may be useful for all persons receiving services.

RECOMMENDATIONS & TIPS

Tips sheets explaining these elements of practice are provided in the *Addenda* to this document.

ADDENDA - TIP SHEETS

Purpose of the Tip Sheets

The Treat First Approach Overview introduces several core practice functions and clinical techniques that can support effective clinical work with persons requesting assistance -- both during and after the first four visits in an episode of care. These Tip Sheets are offered in the spirit of practice development and intended to promote building of craft knowledge needed by frontline practitioners when implementing a Treat First Approach in their agencies.

Tip Sheets define expected outcomes to be achieved when a practice or technique is used and introduce important concepts and strategies related to the practice or technique. Tip Sheets are not meant to serve as a substitute for necessary training and development of staff competencies required to perform these practices and techniques. Rather, Tip Sheets are meant to alert provider staff members and agency leadership that frontline practitioners require the craft knowledge necessary to perform these practices and techniques as well as the organizational supports necessary to integrate them into their everyday work.

Tip Sheets - Title and Order of Presentation

The Tip Sheets are titled and organized as follows on pages 8 through 15:

- Practice Area: Recognition, Connection, and Rapport
- Practice Area: Engagement and Commitment
- Practice Area: Detection and Rapid Response
- Practice Area: Assessment and Formulation
- Practice Area: Wellness and Recovery Goals
- Practice Area: Teamwork - Common Purpose and Unity of Effort
- Clinical Technique: Solution Focused Brief Therapy
- Clinical Technique: Motivational Interviewing

Readers should note that practice areas listed above are core practice functions described in a general framework used for training, supervision, and measurement of practice. That framework is illustrated in the diagram appearing on page 2.

Practice Area: Recognition, Connection, Rapport

Desired Outcomes of Practice

RECOGNITION, CONNECTION & RAPPORT: • The person's sense of identity, culture, values and preferences, social network, and life experiences are recognized by practitioners involved with the person. • Any barriers to personal connection and acceptance are recognized and resolved. • Necessary conditions for building mutual respect and rapport are established as a basis for successful engagement.

Key Concepts

As an early step in building a relationship with a person entering services, practitioners recognize the nature of the person's situation and life story. Recognition involves discovering the circumstances that have brought the person into agency services and anticipating the life changes necessary for the person to make in order to conclude services successfully. Practitioners recognize the person's sense of identity, culture, values and preferences (especially any arising from religious conviction), social and economic supports, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, addiction, emigration, poverty) that explain the person's life story and reasons for entry into services. An important element in the process is recognition of any barriers that could thwart formation of positive connections with the person that could undermine acceptance and rapport building necessary for successful engagement. Successful practitioners take steps for creating conditions necessary for building mutual respect and rapport required in developing trust-based working relationships.

Recognition of a person's identity requires varying degrees of cultural responsiveness, depending on the person involved. Every person has his/her own unique identity, values, beliefs, and world view that shape ambitions and life choices. Some persons may require use of culturally relevant and responsive supports in order to successfully connect, educate, assist, and support them moving through the system. Responsiveness includes valuing cultural diversity, understanding how it impacts family functioning in a different culture, and adapting service processes to meet the needs of culturally diverse groups of persons receiving services. Properly applied in practice, cultural responsiveness reduces the likelihood that matters of language, culture, custom, identity, value, or belief will prevent or reduce the effectiveness of life change efforts undertaken via interventions, supports, and services.

Making sensitive cultural accommodations, where needed, involves a set of strategies used by practitioners to individualize the service process to improve the goodness-of-fit between the person (and the person's supporters) and service providers who work together in the wellness / recovery process. Many persons may require simple adjustments due to differences between the persons and their providers. Such simple adjustments are a routine part of engagement, assessment, planning, and service provision. A person's identity [e.g., race, tribe, ethnicity; social group; sexual orientation; religion; or disability, such as deaf] may shape his or her world view and life goals in ways that must be understood and accounted for in practice. Recognition, connection, and rapport provide a foundation for building and sustaining trust-based working relationships.

Practice Tips

1. LEARN THE REASON the person is seeking help. CONSIDER whether the person's problem can be RESOLVED IN A SINGLE VISIT OR A BRIEF INTERVENTION. DISCERN whether the person's problem is emergent/transient or serious/persistent. DETERMINE whether the reported problem is a present THREAT TO HEALTH OR SAFETY so that any need for crisis intervention or urgent response can be identified and provided.

2. If the person reports being in physical pain or emotional distress, ASK ABOUT its nature, source, history, and impact on the person's life situation. Use the person's responses to form a theory that explains how the pain or distress came about, what causes it to continue, what has been done to alleviate it in the past, what has worked/not worked before, and who else may be helping the person relieve or solve this problem now. *Note: Recognition & Rapport and Detection & Response are performed concurrently by the practitioner when a person is entering services.*

3. In early interactions, DISCOVER the person's sense of identity, culture, values and preferences (especially any arising from religious conviction), world view, social and economic supports, strengths and needs, present life challenges, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, recent loss, addiction, emigration, poverty) that explain the person's situation and reasons for requesting help.

4. IDENTIFY the person's LANGUAGE & CULTURE. DISCERN any impact that cultural or language differences may play in building rapport and forming a working relationship with the person. RECOGNIZE any barriers (arising from culture, language, gender, class, religious or political beliefs, life experiences, sexual orientation, work or family demands, or disability) that could thwart or limit the formation of positive connections with the person that would undermine acceptance and rapport building necessary for developing successful trust-based working relationships.

5. TAKE ACTIVE STEPS in establishing positive conditions for building MUTUAL RESPECT AND RAPPORT with the person.

PRACTICE AREA: ENGAGEMENT & COMMITMENT

Desired Outcomes of Practice

ENGAGEMENT & COMMITMENT. • Service providers are building and maintaining a trust-based working relationships with the person and the person's informal supporters to involve them in ongoing assessment, service planning, and wellness and recovery efforts. • Service providers are using effective outreach and ongoing engagement strategies to increase and sustain the person's participation in the service process and commitment to life changes that support wellness and recovery, consistent with the person's needs and preferences.

Key Concepts

Effective wellness and recovery services depend on effective working relationships between a person in need and the service providers who help meet those needs. Service providers make concerted efforts to reach out to the person, engage him/her meaningfully in all aspects of the service process, establish and maintain a trust-based working relationship, and secure and sustain the person's commitment to a change process. Engagement strategies build a mutually beneficial partnership in decision-making and life change efforts. The person's direct, ongoing, active involvement is used in assessment, planning interventions, selecting providers, monitoring and modifying service plans, and evaluating results. Engagement strategies vary according to the needs of the person and should reflect the person's language and culture.

Building Trust-Based Working Relationships. Building upon recognition of the person's identity, reason for seeking services, and a positive rapport, ongoing engagement efforts are used to form and maintain a trust-based, mutually beneficial working relationship between the person and those serving the person. Practice approaches that support effective relationship building are:

- Person-centered (organizes around the person's goals)
- Strengths-based (builds on the person's positive assets)
- Solution-focused (moves from problems to solutions)
- Need-responsive (recognizes and responds to needs)
- Wellness-oriented and outcome-driven (starts with the end in mind)
- Building readiness for change (uses motivational interviewing strategies)
- Fits the person's stages of change (starts where the person is ready)
- Respect for the person's identity, culture, aspirations, and preferences

In the absence of a trust-based working relationship with the service provider, the person is unlikely to reveal the underlying issues that explain the dynamic circumstances causing the problem that must be solved in order to achieve desired wellness and recovery outcomes.

Building Commitment to Positive Life Change. A major contribution of effective engagement is the person's ongoing commitment to personally choose wellness and recovery outcomes and to the change process used to achieve these outcomes. In the absence of the person's commitment to life change, wellness and recovery outcomes are not likely to be achieved.

Practice Tips

1. Remember that building a relationship with a person involves recognizing the nature of the person's life situation and reasons for requesting help. LISTENING is key to learning, empathy, respect, and trust building. Finding and overcoming any barriers to personal connections are essential. Recognition and rapport provide a foundation for building and sustaining a trust-based working relationship.

2. Use a person-centered approach that puts the person's voice and choice at the center of the service process. Recognize and respond to the person's unmet needs related to wellness, well-being, and daily functioning. Use a solution-focused approach that is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought the person to seek help. Solution-focused practice aims to bring about desired change in the least amount of time. [Tenets of solution-focused practice include: If it's not broken, don't fix it. If it works, do more of it. If it's not working, do something different rather than just trying harder. A solution is not necessarily related to the perceived problem. Small steps in the right direction can lead to big changes.] A strengths-based practice approach emphasizes a person's self-determination and strengths. Identify and build on the person's strengths and assets to create sustainable resources for solutions.

3. Change-oriented approaches are especially useful in addressing lifestyle modification for disease prevention, long-term disease or disorder management, and addiction. Understanding a person's readiness to make change, appreciating barriers to change, and helping anticipate relapse can improve the person's satisfaction and lower practitioner frustration during the change process. A stages of change approach is useful in stimulating change and overcoming resistance

4. Remember that engagement is an ongoing process that builds and sustains: 1) a mutually beneficial trust-based working relationship between the person and 2) a person's commitment to personally selected wellness and recovery outcomes and to the life change process.

Practice Area: Detection & Rapid Response

Desired Outcomes of Practice

DETECTION & EARLY RESPONSE. • A person who is at risk of harm due to safety, health, or situational threats is detected via screening and other means and then kept safe from harm by using rapid response strategies to mitigate risks and protect the person from imminent threats to the person's well-being.

Key Concepts

Detection. Upon admission, screening is performed to identify a person who may have an imminent threat of harm from life partners, caregivers or who may have an undiagnosed health or behavioral condition or who may be at high risk of developing a condition requiring treatment. A person should be screened upon admission and periodically thereafter for certain life situations, conditions, and disorders that may require diagnosis, treatment, and ongoing care. Life situations, conditions, disorders, or diseases for which screening should be routinely performed include:

- Safety/threats of harm at home
- Adverse childhood experiences/complex trauma
- Emotional status/behavioral disorders
- Health status/physical well-being/illness
- Inappropriate or unstable living situation
- Self-endangerment/threats of harm to others
- Intellectual or developmental disability/TBI/learning problems
- Drug/alcohol use/substance use disorder
- Diseases: diabetes, COPD, obesity, hypertension, seizures
- A pattern of instability or a trajectory of physical or emotional decline

Other agencies and practitioners involved in providing services to the person should be identified and contacted to provide necessary opportunities for service delivery, coordination, and integration.

Rapid Response

Rapid Response. Following detection of a threat of harm or an emergent condition, a response is an action taken to avert a safety threat, stop the progression of a disease, control a behavioral disorder, or to mitigate preventable injury or illness. A timely and appropriate response is provided for any person who is detected via a screening process as has having a condition, disorder, or disease for which intervention or treatment is indicated.

A Rapid Response [following the detection of a serious threat or rapidly developing condition]: a response commensurate with the urgency, severity, and intensity of a detected problem, especially when the person is at imminent risk of harm (e.g., sudden death via suicide) or at high risk of a poor health outcome (e.g., a brittle diabetic adolescent who violates dietary restrictions).

Practice Tips

1. Screenings of the person are performed upon admission and periodically thereafter. Practitioners continue to conduct screenings to detect safety, health, and behavioral risks as well as any emergent conditions or disorders as an ongoing assessment process.

2. Based on results of screenings and self-reports by the person, any problems of significance (involving safety, health, or behavioral risks or other situations that could lead to instability or decline) are promptly detected. The nature, significance, and history of any detected problem are defined and reported to any other practitioners or agencies that should be involved in providing an appropriate response to the person's need for prevention, protection, treatment, or care.

3. Any problem requiring a crisis intervention or urgent response is addressed in a timely, appropriate, and sufficient manner so as to prevent unnecessary harm, pain, loss, or hardship for the person. Each response provided is commensurate with the urgency and severity of the presenting problem. Any response provided protects the person from preventable harm or mitigates the impact the problem would have likely had if not treated promptly and effectively.

4. Results of initial and ongoing screenings are incorporated into the ongoing bio-psycho-social assessment and clinical understanding/case formulation of the person's situation. Any significant screening and detection results are used to develop necessary protective interventions and/or treatments to keep the person safe, physically and behaviorally healthy, and functioning effectively in daily life.

PRACTICE AREA: ASSESSMENT & FORMULATION

Desired Outcomes of Practice

ASSESSMENT & FORMULATION. • Ongoing formal and informal fact finding methods are used to develop and update a broad-based understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. • An evolving clinical case formulation (describing the person's clinically significant distress and impairment in functioning) is used to guide development of treatment plans informed by the person's life stage, culture, social context, and preferences.

Key Concepts

Ongoing assessment and clinical case formulation guide the course of action designed and used by service providers to help a person meet wellness and recovery goals that he/she has selected. Assessment processes are used to gather facts and assemble information and knowledge for developing a functional understanding of the person's situation and desired life change outcomes. Assessment provides answers to practical and clinical questions [see the separate list of clinical questions] that are used to develop a working understanding for the person from which treatment decisions are made. Based on the working understanding, a clinical case formulation is developed and updated as new understandings emerge. The formulation is used in developing a course of action (treatment and supports) for meeting the person's wellness and recovery goals.

Assessment & Understanding. As appropriate to the person's situation, a combination of clinical, functional, and informal assessment techniques are used to determine the strengths, needs, risks, underlying issues, and future goals of the person. Once gathered, the information is analyzed and synthesized to form a functional understanding and a bio-psycho-social clinical formulation used in developing a course of action for the person. Assessment techniques, both formal and informal, are appropriate for the person's life stage, ability, culture, language or system of communication, legal issues, and life situation. Areas in which essential understandings are developed include:

- Earlier life traumas, losses, and disruptions
- Learning problems affecting school or work performance
- Subsistence challenges encountered in daily living
- Risks of harm, abuse, neglect, intimidation, or exploitation
- Traumatic brain injury and/or intellectual disabilities
- Court-ordered requirements/constraints/detention
- Recent life disruptions (e.g., eviction, bankruptcy)
- Co-occurring life challenges (mental illness, addiction, domestic violence)
- Significant physical health and/or behavioral health concerns
- Recent tragedy, trauma (including combat trauma), losses, victimization
- Problems of attachment, bonding, self-protective boundaries in relationships
- Recent life changes (e.g., new baby, job loss) requiring major adjustments
- Any significant screening and detection findings (health or safety risks)
- Dislocation due to natural disaster or changes in the local job market

Case Formulation and Clinical Reasoning. Understandings developed from ongoing assessments are used to create a clinical case formulation that guides service decisions and actions. Clinical reasoning is applied in moving from understanding to action: Any compelling urgency is addressed first. Practical solutions may precede clinical solutions in the course of action. Plans develop from outcome to action. Opportunities for early and repeated successes are identified and pursued. A pace of action that could overwhelm the person is avoided.

Practice Tips

1. Remember that the outcome of assessment is an essential FUNCTIONAL UNDERSTANDING of the person used in case formulation to guide intervention planning. Assessment is a continuous learning process involving the person and service providers, not a form to complete upon intake or other points in the course of action. Assessment includes the gathering and assembly in facts, information, and knowledge to develop a broad-based understanding of the person's situation used to support decision making.

2. A clinical case formulation includes a clinical history and concise summary of the bio-psycho-social factors contributing to the present disorder. It focuses on clinically significant distress and impairment in functioning experienced by the person. The case formulation considers the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern.

3. Practical reasoning and clinical judgment are used in making a reliable assessment of factors related to a person's disruption in daily functioning or role fulfillment. Functional understandings and clinical case formulation are used to guide development of a comprehensive treatment plan, including support plans where indicated, informed by the person's life stage, culture, social context, and preferences.

4. Principles of person-centered practice and self-directed care are applied in all aspects of assessment and clinical case formulation.

PRACTICE AREA: WELLNESS & RECOVERY GOALS

Desired Outcomes of Practice

WELLNESS & RECOVERY GOALS: • Clearly stated, well-informed, and personally-selected wellness and recovery goals are developed with the person and used to guide intervention strategies toward attainment of desired levels of well-being, supports for living, daily functioning, inclusion, productivity, and role fulfillment for the person.

Key Concepts

WELLNESS is an active process in which a person becomes aware of and makes choices toward a more successful existence. Wellness is a conscious, self-directed, and evolving process of achieving full potential. Wellness is a multidimensional and holistic, encompassing lifestyle, mental and spiritual wellbeing, and the environment. Wellness is positive and affirming. [National Wellness Institute]

RECOVERY is a process through which persons improve their health and wellness, live a self-directed life, and strive to reach their full potential. Ten guiding principles of recovery are: hope, person-driven, many pathways, holistic, peer support, relational, culture, responsive to trauma, strengths and responsibility, and respect. [SAMHSA]

Consistent with the principles of person-centered practice, personally-selected wellness and recovery goals vary among persons having a wide range of personal needs, aspirations, and life trajectories reflective of their age, ability, and situation:

- A person experiencing a simple, acute problem, but having no systematic barriers or impediments, should improve quickly and reach desired levels of well-being, sustainable supports, daily functioning, and independence with minimal assistance and limited interventions.

- A person experiencing a chronic problem with minimal systematic barriers or impediments should achieve adequate levels of stability, functioning, and well-being while self-managing the condition as independently as possible until he/she requires more intensive temporary care or treatment. Once the person regains adequate levels of stability, functioning, and/or well-being, he/she resumes self-management of the condition with a lower level of ongoing monitoring and support from the system.

- A person having limited capacities and/or major systematic barriers or impediments should achieve and maintain his/her best attainable level of functioning, well-being, and support until his/her status changes. Persons having intellectual disabilities, serious and persistent mental illness, traumatic brain injury, and the frail elderly often require more intensive or specialized long-term care services.

Personal wellness and recovery goals specify: (1) Levels of well-being, supports, daily functioning, productivity, or social integration to be achieved by the person; (2) Aspirations for fulfilling life roles (e.g., employee, parent, life partner, grandparent) the person seeks to achieve including the manner and degree of accomplishment; and (3) Any requirements to be met (e.g., discharge from hospital or detention) before interventions are transitioned to either ongoing maintenance services (e.g., self-management with monitoring, reunification of children from foster care) or independence from the service system. Wellness and recover recovery goals define outcomes to be accomplished via services.

Practice Tips

1. Use person-centered planning techniques to help the person identify and state what he/she expects to gain or achieve from the service process. Frame these expectations as wellness or recovery goals using the person's own words. Make sure the goals selected for service planning are based on the person's assessed needs, expressed aspirations for wellness and recovery, and socially-beneficial choices.

2. Construct goals that are SMART: Specific, Measurable, Achievable, Relevant, and Time-bound. Clear goals help in planning intervention strategies and measurement of results. Relevant and achievable goals promote the person's motivation and commitment to the change process.

3. Consider the nature, purpose, trajectory, time required, person's motivation, and opportunities available for achieving the goals selected. Recognize that there may be an important order of priority in which goals are addressed. Any compelling urgencies should be addressed first.

4. Use the person's wellness and recovery goals to guide the selection of strategies to be used for their attainment. Identify goals for which the involvement of other practitioners or agencies will be involved in or responsible for the helping the person achieve the desired outcomes.

5. Use teamwork processes to build common purpose and unity of efforts with other supporters, practitioners, and agencies involved in helping the person achieve his or her wellness and recovery outcomes.

PRACTICE AREA: TEAMWORK / COMMON PURPOSE & UNITY OF EFFORT

Desired Outcomes of Practice

TEAMWORK / COMMON PURPOSE & UNITY OF EFFORT. • Using a shared-decision making process, the person and the person's practitioners and supporters are building and sustaining: • Common purpose by planning wellness/recovery goals and strategies together with the person. • Unity of effort in service delivery by coordinating actions of the person's providers and integrating services across providers, settings, time, and funding sources.

Key Concepts *[These Aspects of Practice are Applied to Persons Having Complex Needs and Ongoing Services]*

Person-centered practices and self-directed care principles put the person's needs, aspirations, and choices at the center of service organization. A team-based, shared decision-making process helps the person to create a vision for a better life based on aspirations for wellness, valued social roles, social inclusion, and successful daily living. Informal supporters and service providers join with the person (consistent with the person's preferences) to define wellness/recovery goals to be achieved along with related strategies for provision of supports and services. Because the efforts of many may be involved in helping the person, achieving common purpose and unity of effort are essential for success. Together, common purpose and unified efforts create the "glue" that holds things together in practice for the benefit of the person receiving services.

Common Purpose. Common purpose is created when the people involved agree upon and commit to clear goals and a related course of action. An ongoing, person-centered, team-based, shared decision-making process may be used to achieve and maintain a consensus on and commitment to a set of wellness/recovery goals and related strategies. These goals and strategies are determined by and with the person, the person's primary supporters, and the service providers involved. CONSENSUS and COMMITMENT are essential for building common purpose.

Unity of Effort. Unity of effort is based on: (1) A common understanding of the person's situation; (2) A common vision for the person's wellness or recovery; (3) Coordination of efforts to ensure coherency and continuity; (4) Common measures of progress and ability to change course, if necessary. Unity of effort is achieved and maintained via ongoing teamwork, coordination of actions among providers and supporters, and integration of services across providers, settings, funding sources, and points in time. Unity of effort is the state of harmonizing actions and efforts among multiple service providers and supporters who are commited to helping the person achieve agreed upon goals and shared outcomes.

Practice Tips

1. Remember that effective TEAMWORK and SERVICE COORDINATION help build common purpose and unity of effort in frontline practice. Effective teamwork involves having the right people working together with and for the person being served. The team should have the technical and cultural competence, knowledge of the person, authority to act on behalf of funding agencies and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person. NOTE: Persons having serious, persistent illnesses (requiring ongoing care and treatment) benefit most from effective teamwork and service coordination. Person-centered teams are useful for persons receiving multiple ongoing care and treatment services

2. The person's team assists in conducting person-centered planning activities and in providing assistance, support, and interventions after plans are made in order to meet the person's wellness/recovery goals. Working together, team members support the person in identifying needs, setting wellness/recovery goals, and planning strategies with related services that will enable the person to meet those goals. Effective, ongoing, collaborative problem solving is a key indicator of effective team functioning.

3. Leadership and coordination are necessary to: (1) form a person-centered team and facilitate teamwork; (2) plan, implement, monitor, modify, and evaluate services provided; (3) integrate strategies, activities, resources, and interventions agreed to by the team; (4) measure and share results for the individual in order to change strategies that do not work and to determine progress; and (5) ensure a unified process involving a shared decision-making approach. While leading and coordinating may be appropriately discharged by a variety of team members, it is most effectively accomplished by a designated leader who prepares team members, convenes and organizes meetings, facilitates team decision-making processes, and follows up on commitments made. Individual(s) filling these roles should have strong facilitation skills, authority to act, and, as appropriate to role, clinical skills in assessing, planning, monitoring, and evaluation. In a case where several agencies and providers are involved, negotiation may be necessary to achieve and sustain a coordinated and effective service process. Leadership and coordination responsibilities can be shared with an empowered and capable service recipient. This may be an appropriate outcome of interventions for the person receiving services.

3. Team functioning and decision-making processes should be consistent with principles of person-centered practice and self-directed care. Evidence of effective team functioning over time is demonstrated by the quality of relationships built, commitments fulfilled, results achieved, unity of effort shown by all members of the team, the focus and proper fit of services assembled for the person, dependability of service system performance, and connectedness of the person to critical resources necessary for achieving wellness/recovery goals.

Clinical Technique: Solution Focused Brief Therapy

Desired Outcomes of Practice

SOLUTION FOCUSED BRIEF THERAPY: • The person's concerns and reasons for requesting help are clarified. • The person's aspirations and vision for a preferred future are stated. • The person demonstrates motivation and confidence in finding solutions. • The person's strengths and past successes are used to build solutions. • The person is taking small steps in the right direction toward a preferred future.

Key Concepts

A practice that may be useful in a Treat First Approach is Solution Focused Brief Therapy (SFBT) that focuses on a person's strengths and previous successes rather than failings and problems. SFBT consists of conversations that stimulate and support positive life change for a person receiving services. These conversations are centered on the person's concerns; who and what are important to the person; a vision of a preferred future; the person's exceptions, strengths, and resources related to the vision; scaling of the person's motivation level and confidence in finding solutions; and, ongoing scaling of the person's progress toward reaching the desired future. The goal is helping a person rapidly find a solution to a resolvable life problem. The basis for a brief intervention builds on the person's understanding of his/her concern or situation and what the person wants to be different in the future.

Basic concepts of SFBT are:

- It is based on solution-building, not problem-solving.
- It encourages the person to increase the frequency of useful behaviors.
- The person and provider create solutions based on what has worked in the past.
- It asserts that small steps in the right direction lead to larger changes.
- It is focused on the person's desired future, not the past.
- It assumes that solution behaviors already exist for the person.
- It places responsibility for change on the person.

SFBT has been recognized as an evidence-based practice and is listed on the SAMHSA National Registry of Evidence-Based Programs and Practices.

Solution-Focused Questions

Solution-focused questions about the topics of conversation are used to connect to and build on the concerns and aspirations expressed by the person. Examples of solution-focused questions include:

- Given the issue or problems you are faced with, what are you hoping we can achieve together?
- How would you like your life to change in regard to the issues we have been discussing?
- Are there things you have tried already to solve this problem?
- What are some things you have already accomplished that you are pleased with?
- What types of support do you have from family/community/resources?
- What personal traits, skills, and talents have helped you in the past?
- What personal qualities are helping you get through these difficult times right now?
- How is it you found the strength and wisdom to come here for help?
- What do you suppose you do or have done so that the problem isn't any worse?
- With such difficulties in your life, how have you been able to get up and face each day?
- How are your life and your functioning affected by having a diagnosis of _____?
- What have you tried in the past when confronted with these types of problems?
- Would this type of solution help with your situation now?
- When you have achieved your goal, what are some things you will experience that will let you know that your goal has been accomplished?
- If your problem suddenly went away, what would be the first thing you would notice about yourself (how would be feeling, thinking, doing)?
- How would those around you know that this big change had occurred?
- What will be different in your life when the problem is gone?

Clinical Technique: Motivational Interviewing

Desired Outcomes of Practice

MOTIVATIONAL INTERVIEWING: • The person is increasingly aware of the potential problems caused, consequences experienced, and risks faced as a result of a particular behavior. • The person envisions a better future and becomes increasingly motivated to achieve it.

Key Concepts: Motivational Interviewing is a Technique Used with Solution Focused Brief Therapy

Motivational interviewing is a method that works on facilitating and engaging intrinsic motivation within the person in order to change behavior. The examination and resolution of ambivalence is a central purpose and the practitioner is intentionally directive in pursuing this goal. Motivational interviewing is a semi-directive, person-centered counseling style for eliciting behavior change by helping a person to explore and resolve ambivalence. It is change-focused and goal-directed. Motivational interviewing is non-judgmental, non-confrontational and non-adversarial. Motivational interviewing recognizes and accepts the fact that persons who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. Some persons may have thought about it but not taken steps to change it or may be actively trying to change behavior and may have been doing so unsuccessfully for years. In order for a practitioner to be successful at motivational interviewing, four basic skills should first be established: 1) The ability to ask*open-ended questions*. 2) The capacity for *reflective listening*. 3) The ability to provide *affirmations*. 4) The ability to periodically provide *summary statements* to the person. The motivational approach attempts to increase the person's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Alternately, practitioners help the person envision a better future, and become increasingly motivated to achieve it. The strategy seeks to help the person think differently about their behavior and ultimately to consider what might be gained through change.

Motivational interviewing focuses on the present and entails working with a person to access motivation to change a particular behavior that is not consistent with a person's personal value or goal. *Warmth*, *genuine empathy*, and *unconditional positive regard* are necessary to foster therapeutic gain within motivational interviewing. The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment language from the person. A central concept is that ambivalence about decisions is resolved by conscious or unconscious weighing of pros and cons of making change versus not changing. It is critical to meet people where they are and to not force a person towards change when they have not expressed a desire to do so. The four general principles are:

1. **Express Empathy**. Empathy involves seeing the world through the person's eyes, thinking about things as the person thinks about them, feeling things as he or she feels them, sharing in the person's experiences. The practitioner's accurate understanding of the person's experience facilitates change.

2. **Develop Discrepancy**. This guides practitioners to help persons appreciate the value of change by exploring the discrepancy between how the person wants his or her life to be versus how it is currently (or between their deeply-held values and their day-to-day behavior). Practitioners work to develop this situation through helping persons examine the discrepancies between their current behavior and future goals.

3. **Roll with Resistance**. The practitioner does not fight a person's resistance, but "rolls with it." Statements demonstrating resistance are not challenged. Instead the practitioner uses the person's "momentum" to further explore his or her views. Using this approach, resistance tends to be decreased rather than increased, as persons are not reinforced for becoming argumentative. Motivational interviewing encourages persons to develop their own solutions to the problems that they themselves have defined.

4. **Support Self-Efficacy**. This guides practitioners to explicitly embrace the person's autonomy (even when persons choose to not change) and help the person move toward change successfully and with confidence. As persons are held responsible for choosing and carrying out actions to change, practitioners focus their efforts on helping people stay motivated, and supporting their sense of self-efficacy is a great way to do that.

Key points on Motivational Interviewing are:

- Motivation to change is elicited from the person and is not imposed from outside forces.
- It is the person's task, not the counselor's, to articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- The counseling style is generally quiet and elicits information from the person.
- The counselor is directive, in that they help the person to examine and resolve ambivalence.
- Readiness to change is not a trait of the person, but a fluctuating result of interpersonal interaction.
- The therapeutic relationship resembles a partnership or companionship.

Thus, motivational interviewing uses an ongoing conversation about life and change as a basis for engagement and encouragement.

APPENDIX R

Treat First Trial
Client Check-In instruments

Purpose

A **Self Check-In** is conducted with the person at the beginning of each visit and a **Session Check-Out** is conducted at the end of each visit. Relative rating scale results are used by the practitioner to evaluate the client's perspective on how he/she are doing at the beginning of the session, and how useful and beneficial the session has been in making progress towards achieving the person's desired future

How to use

The following instruments will be loaded on a web-based data collection application for each practitioner's use with clients in the Treat First trial. At the beginning and end of the first 4 visits, complete the questions with each client identified for participation in the trial. It is recommended that the practitioner invite the client to enter their responses directly into the computer themselves. If it is deemed necessary, the practitioner can assist the client by reading the questions or entering their responses. A simple graph will be generated after the data are entered.

In addition to providing the client opportunity for input into their work towards their identified goals, these tools can also be beneficial to the practitioner by prompting discussion around the client's assessment of either their wellbeing or the session itself. This can help the client clarify or hone in on their identified goals, as well as providing the practitioner with real-time feedback that can further improve the focus of future sessions.

Adult Self Check-In and Session Check-Out Instruments

Self Check-In (at the beginning of the visit)

Introduction: *Looking back over the last week, including today, let me know how you have been doing by rating things on a scale of 1 to 10. A "1" would be <u>not very well</u> and a "10" would be <u>very well.</u>*

SELF CHECK-IN

1. How would you rate how you are doing today?	1……2……3……4……5……6……7……8……9…..10 Very Low Very High
2. How would you rate how things are going in your personal life?	1……2……3……4……5……6……7……8……9…..10 Very Low Very High
3. How would you rate how things are going in your social/work life?	1……2……3……4……5……6……7……8……9…..10 Very Low Very High
4. How would you rate how things are going in your life overall?	1……2……3……4……5……6……7……8……9…..10 Very Low Very High

Session Check-Out (at the end of the visit)Introduction: *Please rate how you felt about your experience in today's session. A "1" would be a very low level and a "10" would indicate a very high level.*

SESSION CHECK-OUT

1. How would you rate how well you felt heard today?	1……2……3……4……5……6……7……8……9…..10 Very Low Very High
2. How would you rate whether we covered what you wanted to discuss today?	1……2……3……4……5……6……7……8……9…..10 Very Low Very High
3. How would you rate how you and I connected today?	1……2……3……4……5……6……7……8……9…..10 Very Low Very High
4. How would you rate our work together overall?	1……2……3……4……5……6……7……8……9…..10 Very Low Very High
Today was our final session.	Yes__ No___
We have scheduled a follow-up session	Yes__ No_

Child/Youth Self-In and Session Check-Out Instruments

Self Check-In (at the beginning of the visit)

Introduction: How are you doing? How are things going in your life? Circle a number on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a care giver filling out this form, please fill out according to how you think the child is doing.*

SELF CHECK-IN

1. How am I doing today?	1……2……3……4……5 ☹ ☺
2. How are things going in my family right now?	1……2……3……4……5 ☹ ☺
3. How are things going at school?	1……2……3……4……5 ☹ ☺
4. How is everything going	1……2……3……4……5 ☹ ☺

Session Check-Out (at the end of the visit)

Introduction: *How was our time together today? Circle the number below to let us know how you feel.*

Listening

Did not listen to me today.	1……2……3……4……5 ☹ ☺	Did Listen to me Today

What I want

We did not talk about what I wanted to.	1……2……3……4……5 ☹ ☺	We did talk about what I wanted to

What We did Today

I did not like what we did today	1……2……3……4……5 ☹ ☺	I liked what we did today

Next Time

Next time, I wish we could do something different	1……2……3……4……5 ☹ ☺	Next time I'd like to do the same kind of things

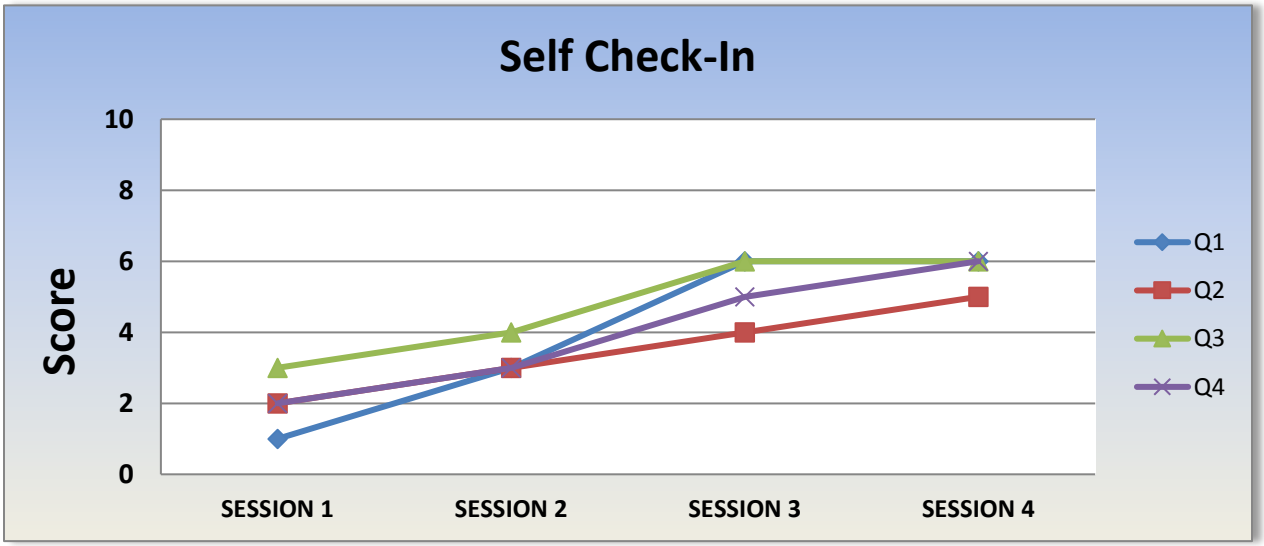
Today was our final session. Yes__ No___

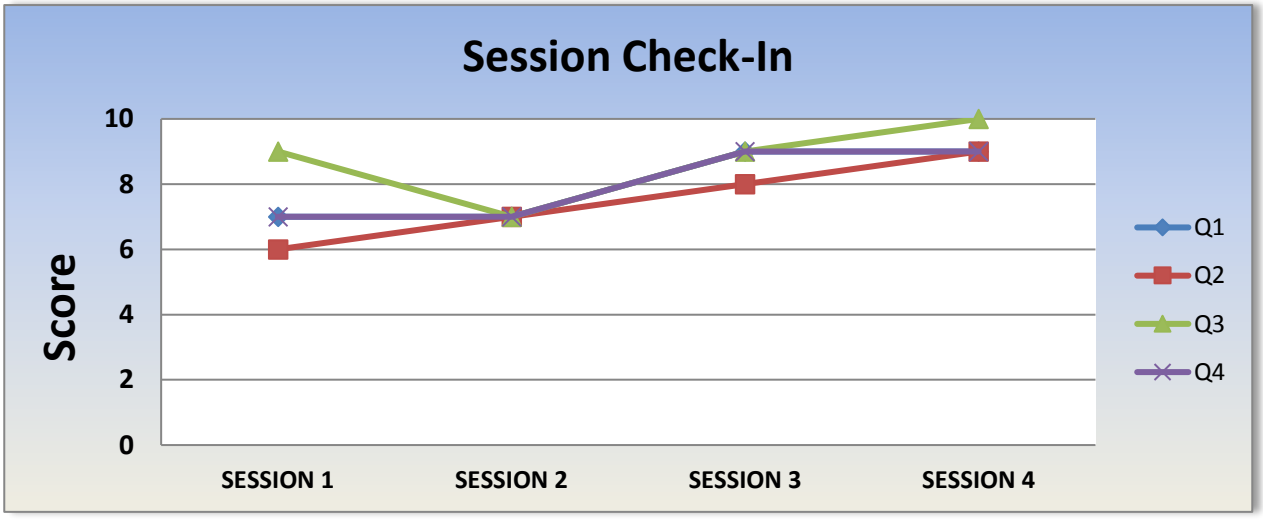
We have scheduled a follow-up session Yes__ No_

Example of Graphs available for Adult Check-In Data

SELF CHECK-IN		SESSION 1	SESSION 2	SESSION 3	SESSION 4
1. How would you rate how you are doing today?	Q1	1	3	6	6
2. How would you rate how things are going in your personal life?	Q2	2	3	4	5
3. How would you rate how things are going in your social/work life?	Q3	3	4	6	6
4. How would you rate how things are going in your life overall?	Q4	2	3	5	6

SESSION CHECK-OUT		SESSION 1	SESSION 2	SESSION 3	SESSION 4
1. How would you rate how well our session was today?	Q1	7	7	9	9
2. How would you rate whether we covered what you wanted to discuss today?	Q2	6	7	8	9
3. How would you rate how you and I connected today?	Q3	9	7	9	10
4. How would you rate our work together overall?	Q4	7	7	9	9





APPENDIX T

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CARELINK NM
YOUR CARE. OUR COMMUNITY.

Clinical Screen

Over the last two weeks, how often have you been bothered by any of the following problems? (please check your answer and circle the boxes that apply to you)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Felling down, depressed, or hopeless	0	1	2	3
☐ Thoughts that you would be better off dead or, ☐ Hurting yourself in some way	0	1	2	3
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

Standard serving of one drink:
12 ounces of beer or wine cooler
1.5 ounces of 80 proof liquor
5 ounces of wine
4 ounces of brandy, liqueur or aperitif

Please circle your answer

How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month, you:

Have had nightmares about it or thought about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

Anxiety Screen				
Over the last two weeks, how often have you been bothered by any of the following problems? (please circle your answer)				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Worrying too much about different things	**0**	**1**	**2**	**3**
Trouble relaxing	**0**	**1**	**2**	**3**
Being so restless that it is hard to sit still	**0**	**1**	**2**	**3**
Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
Feeling afraid, as if something awful might happen	**0**	**1**	**2**	**3**

Audit-10					
Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking. **These questions are about your drinking habits. We've listed the serving size of one drink below.**					
Standard serving of one drink: **12 ounces of beer or wine cooler** **1.5 ounces of 80 proof liquor** **5 ounces of wine** **4 ounces of brandy, liqueur or aperitif**					
Please circle your answer					
How often do you have one drink containing alcohol?	**Never**	**Monthly or less**	**2-4 times a month**	**2-3 times a week**	**4+ times a week**
How many drinks containing alcohol do you have on a typical day when you are drinking?	**1 or 2**	**3 or 4**	**5 or 6**	**7 to 9**	**10 or more**
How often do you have four or more drinks on one occasion?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
How often during the last year have you…					
found that you were not able to stop drinking once you had started?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
failed to do what was normally expected from you because of drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
needed a first drink in the morning to get yourself going after heavy drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
had a feeling of guilt or remorse after drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**

been unable to remember what happened the night before you had been drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
Have you or someone else been injured as a result of your drinking?	**No**	**Yes, but not in the last year**			**Yes, during the last year**
Has a relative, friend, doctor, or health worker been concerned about your drinking or suggested you cut down?	**No**	**Yes, but not in the last year**			**Yes, during the last year**
The Columbia Scale (C-SSRS)					
In the past month					
Have you wished you were dead or wished you could go to sleep and not wake up?				**Yes**	**No**
Have you actually had any thoughts about killing yourself?				**Yes**	**No**
If you answered Yes to 2, answer 3,4,5, and 6. If you answered No to 2, go directly to question 6.					
Have you thought about how you might do this?				**Yes**	**No**
Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?				**Yes**	**No**
Have you started to work out or worked out details of how to kill yourself?				**Yes**	**No**
Do you intend to carry out this plan?				**Yes**	**No**
In the past 3 months					
Have you done anything, started to do anything, or prepared to do anything to end your life? ***Examples: Collected pills, obtained a gun, given away valuables, wrote a will or suicide note, took put pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.***				**Yes**	**No**
In your entire lifetime, how many times have you done any of these things?					
Depression Survey					
Over the last two weeks, how often have you been bothered by any of the following problems? (please check your answer and <u>circle the boxes that apply to you</u>)					
	Not at all	**Several days**	**More than half the days**	**Nearly every day**	
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**	
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**	
☐ **Trouble falling or staying asleep or,** ☐ **Sleeping too much**	**0**	**1**	**2**	**3**	
Feeling tired or having little energy	**0**	**1**	**2**	**3**	
☐ **Poor appetite or,** ☐ **Overeating**	**0**	**1**	**2**	**3**	

	Not at all	Several days	More than half the days	Nearly every day
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
☐ Moving or speaking so slowly that other people could have noticed or, ☐ The opposite-being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
☐ Thoughts that you would be better off dead or, ☐ Hurting yourself in some way	0	1	2	3

PC-PTSD		
In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month, you:		
Have had nightmares about it or thought about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

Adult Member Information		
Background		
What brought you in for services today?		
Would you like an interpreter?	Yes	No
Do you have a developmental/intellectual disability?	Yes	No
If Yes, do you have an Individual Service Plan related to your developmental/intellectual disability?	Yes	No
Do you have an Emergency Crisis Plan? (if yes, please provide a copy)	Yes	No
Were you referred?	Yes	No
If yes, by whom were you referred?		
Nursing Facility Level of Care (NFLOC)?		
Height and Weight		
Height (in inches)		
Weight (in pounds)		
Exam Dates		
Date of last physical exam	_ _/_ _/_ _ _ _	Don't Know
Date of last dental exam	_ _/_ _/_ _ _ _	Don't Know
Date of last vision exam	_ _/_ _/_ _ _ _	Don't Know
Date of last hearing exam	_ _/_ _/_ _ _ _	Don't Know
Date of last bone density exam	_ _/_ _/_ _ _ _	Don't Know

Care Team				
Care Coordinator				
Name				
Primary Care Provider				
Name				
Phone Number (###-###-####)				
Behavioral Health Therapist				
Name				
Phone Number (###-###-####)				
Plan of Care				
Short-term Goals; 0-3 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Short-term Goals; 0-3 Months				
Goal				
Intervention				
Progress				

Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Long-term Goals; 3-12 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Long-term Goals; 3-12 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Self Management Goals				
Goal				

Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Self Management Goals				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Future Opportunities				
Demographics/Psychosocial				
Name of person filling out assessment				

Relationship of person filling out assessment to the person coming in today	**Self**	**Parent/ Guardian**	**Friend**	**Other**
If Other please describe				

Are there cultural or religious preferences that you would like your provider to be aware of today?	**Yes**	**No**	**Prefer not to answer**
If Yes please describe			

General Health Information						
Are you currently in any physical pain?					Yes	No
How much pain are you in today? Please enter best response, with 0 being no pain and 10 being the most pain you have ever had.						
Where is your pain?						
Have you ever had a traumatic brain injury (head injury, concussion)?					Yes	No
Do you need help with transportation to appointments?					Yes	No
In general, would you say your physical health is:	Excellent	Very Good	Good	Fair	Poor	Prefer not to answer
In general, would you say your mental health is:	Excellent	Very Good	Good	Fair	Poor	Prefer not to answer
Have you had any psychiatric hospitalization in the last 6 months?				Yes	No	Prefer not to answer
Are you currently taking atypical psychotropic medications, such as Ability, Clozaril, Zyprexa, Seroquel, Risperdal, or Geodon?				Yes	No	Prefer not to answer
How much are you bothered by medication side effects (for example, shaking and trembling, not being able to think clearly, gaining or losing weight, or sexual problems)?	Not bothered at all	Bothered a little	Bothered moderately	Bothered a lot	Prefer not to answer	

Diagnosis
Diagnosis

Member Goals
Member Goals

Home Life		
How may people live in your home, including you?		
Who lives in your home with you? (circle all that apply)		
Mother	Stepmother	Father
Stepfather	Two Mothers	Two Fathers
Mother's boyfriend	Father's girlfriend	Boyfriend/partner
Girlfriend/partner	Spouse/Partner's Mother or Father	Grandmother(s)
Grandfather(s)	Aunt(s)	Uncle(s)
Cousin(s)	Foster Parent(s)	Friend(s)
Other Relative(s)	Pet(s)	None of these apply

What is your current living arrangement? (circle one)	
Homeless	Dependent Living
Dependent Living: Residential Care	Dependent Living: Foster Care/Foster Home
Dependent Living: Crisis Residence	Dependent Living: Institutional Setting
Dependent Living: Jail/Correctional Facility/Other Institutions Under the Justice System	Dependent Living: Private Residence

Independent Living				Unknown	Private Residence, Living Arrangement not Specified			
Have you been homeless at any time in the last 6 months?						Yes	No	Prefer not to answer
Are you having any problems at home? (circle all that apply)								
Violence			Money			Fighting		
House			Food			Gas		
Electricity			Water			Cooling		
You are out of work			Spouse/Partner out of work			Substance use of others		
Concerns with a family member			Do not have any of these problems					
Would you like to discuss this with someone?						Yes	No	Prefer not to answer
Current Providers								
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Resources								
Community Resources and Services Being Utilized								
Resource					Service (circle all that apply)			
Income Support Division								
Medicaid	CHIP	SNAP	TEFAP	TANF	GA	RRS	LIHEAP	CSBG
Behavioral Health Services Division (BHSD)								
Mental Illness Treatment					Substance Abuse Treatment			
Aging and Long Term Services Department (ALTSD)								
Consumer and Elder Rights Division (CERD) Assistance					Aging Network Division (AND) Assistance			
Child Support Enforcement Services (CSES)								
Paternity Establishment					Collection/Enforcement			
Children Youth and Families (CYFD)								
Early Childhood Services			Protective Services			Juvenile Justice Services		
Department of Health (DOH)								
Immunizations					WIC			
Religious Organization								
Emergency Housing (Short Term/Transitional)			Emergency Food			Other		
Section 8 Housing								
Section 8 Housing								

Needed Community Resources and Services								
Resource					Service (circle all that apply)			
Income Support Division								
Medicaid	CHIP	SNAP	TEFAP	TANF	GA	RRS	LIHEAP	CSBG
Behavioral Health Services Division (BHSD)								
Mental Illness Treatment					Substance Abuse Treatment			
Aging and Long Term Services Department (ALTSD)								
Consumer and Elder Rights Division (CERD) Assistance					Aging Network Division (AND) Assistance			
Child Support Enforcement Services (CSES)								
Paternity Establishment					Collection/Enforcement			
Children Youth and Families (CYFD)								
Early Childhood Services			Protective Services			Juvenile Justice Services		
Department of Health (DOH)								
Immunizations					WIC			
Religious Organization								
Emergency Housing (Short Term/Transitional)			Emergency Food			Other		
Section 8 Housing								
Section 8 Housing								
Disaster Plan								
Disaster Preparedness Plan								
Adult Health & Well-Being								
Health Behaviors								
In the past three months have you smoked cigarettes or used any form of tobacco (e.g. chew, dip, cigars, hookah and/or e-cigarettes)?							Yes	No
Have you ever ridden in a car driven by someone (including yourself) that was high or was using alcohol or drugs?							Yes	No
Does anyone in your home take opioids for an ongoing medical condition ? (OxyContin, Hydrocodone, Codeine)							Yes	No
Do you lock your opioid medications in a medicine cabinet or other locked location?							Yes	No
Do you have a smoke detector in your home?							Yes	No
Do you have gas heating or appliances in your home?							Yes	No
Do you have carbon monoxide detector in your home?							Yes	No
Caregiver								
Do you have a caregiver that comes into the home, because of a health care problem, to provide you with assistance?							Yes	No
Is caregiver a relative, friend or from an agency?						Relative	Friend	Agency
Caregive/Agency Name								
Caregive/Agency phone number (###-###-####)								

Caregive/Agency Specialty				
How many hours per day/week does caregiver come into your home? **(☐ per day, or ☐ per week)**				
What items does your caregiver help with?				
Do you need more help than you are receiving?			**Yes**	**No**
Please explain:				
ADL/IADL				
Please indicate your ability to do the activities in the table below. **If you are Receiving Help for any of these, indicate Yes or No,**				
Bathing				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Dressing				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Grooming				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Mouth care				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Toileting				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Transferring bed/chair				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Walking				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Climbing Stairs				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Eating				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Shopping				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Cooking				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	

Manging medications				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Using phone book/ looking up numbers				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Doing housework				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Doing laundry				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Driving or using public transportation				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Managing finances				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	

Sleep				
On average how many hours of sleep do you get in a 24 hour period				
Do you feel your sleep is restful?			**Yes**	**No**

Employment			
What is your current type of employment?			
Employed-Full time	**Employed-Part time**	**Not employed, but seeking employment**	
Not employed, not seeking employment	**Not in labor force (e.g. retired, disabled, homemaker, student, volunteer**	**Prefer not to answer**	
If not employed (circle all that apply):			
I am in the the process of seeking benefits or I don't want to risk losing my benefits	**I worry that my symptoms will interfere with my work**	**I'm not sure how to go about getting a job**	
Not applicable	**Other**	**Prefer not to answer**	
If employed, how many hours do you work per week			

Durable Medical Equipment				
Air-fluidized beds and other support surfaces	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Bar in toilet/shower	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Blood sugar (glucose) test strips	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Blood sugar monitors	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Canes (however, white canes for the blind aren't covered)	**Have**	**Want**	**Wish to discuss**	**Don't Need**

Commode chairs	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Continuous passive motion (CPM) machine	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Crutches	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Eyeglasses/contacts	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Hearing aid or other hearing equipment	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Hospital beds	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Infusion pumps and supplies (when necessary to administer certain drugs)	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Manual wheelchairs and power mobility devices	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Nebulizers and nebulizer medications	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Oxygen equipment and accessories	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Patient lifts	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Shower bench	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Suction pumps	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Traction equipment	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Translation devices	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Walkers	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Wheelchair	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Do you have other adaptive equipment that is not listed above?			**Yes**	**No**
If yes, please describe:				
Do you want other adaptive equipment that is not listed above?			**Yes**	**No**
If yes, please describe:				

Legal					
Do you have an advance directive and/or living will?			Yes	No	Don't Know
Do you have a copy of your advance directive and/or living will to put in your record?				Yes	No
Do you have a psychiatric advance directive?			Yes	No	Don't Know
Do you have a copy of your advance directive and/or living will to put in your record?				Yes	No
Have you given Power of Attorney (POA) to someone?				Yes	No
If yes, who?					
Do you have a copy of your POA to put in your record?				Yes	No
In the past six months, have you been arrested?	Yes	No	Don't know	Prefer not to answer	Not applicable
In the past six months, were you the victim of any violent crimes, such as assault, rape,	Yes	No	Don't know	Prefer not to answer	Not applicable
Safety/Injuries					
Do you have a gun/firearm in the home?				Yes	No
If yes, is it unloaded?				Yes	No
If yes, is it locked up?				Yes	No
During the past 12 months did you smoke any marijuana or hashish?				Yes	No
During the past 12 months did you use anything else to get high (includes illegal drugs, over-the-counter and prescription drugs, and things you sniff or huff?				Yes	No
Please answer the following if you answered yes to either of the last two questions above. Otherwise, leave the following blank.					
Do you use drugs to relax, feel better about yourself or fit in?				Yes	No
Do you ever use drugs while you're by yourself, alone?				Yes	No
Have you ever gotten into trouble while you were using drugs?				Yes	No
Do you ever forget things you did while using drugs?				Yes	No
Does your family or friends ever tell you that you should cut down on your drug use?				Yes	No
Client Concerns					
What are your future plans for work, career and family goals?					
Financial Support					
In the past six months, did you generally have enough money each month to cover food?				Yes	No
In the past six months, did you generally have enough money each month to cover clothing?				Yes	No
In the past six months, did you generally have enough money each month to cover housing?				Yes	No

In the past six months, did you generally have enough money each month to cover traveling around to get things, shopping, medical appointments, or visiting friends or relatives?	Yes	No
In the past six months, did you generally have enough money each month to cover social activities like movies or eating in restaurants?	Yes	No
In the past six months, did you generally have enough money each month to cover Heating, air conditioning, water, electricity, gas?	Yes	No
Have you received mental health or developmental disability services?	Yes	No
Do you have questions you would like to discuss with your provider?	Yes	No
Do you know what benefits are available to you?	Yes	No
Do you feel your benefits meet your needs?	Yes	No
Clinical Summary		
Allergies		
Medication allergies	Yes	No
If yes, what are they?		
Food allergies	Yes	No
If yes, what are they?		
Environmental allergies (hay fever, dust, etc.)	Yes	No
If yes, what are they?		
Pharmacy Name		
Pharmacy Location		
Pharmacy phone number (###-###-####)		

Current Medications

Medication	Dose (if known)	How often do you take them?	Start Date	What are they for?

Previous medications: Only list atypical anti-psychotics from the following: Risperdal (Risperidone), Seroquel (Quetiapine), Geodon (Ziprasidone), Zyprexa (Olanzapine), Invega (Paliperidone), Saphiris (Asenipine), Clozaril (Clozapine), Abilify (Aripiprazole), Latuda (Lurasidone), Vraylar (Cariprazine), Rexulti (brexpiprazole)					
Medication	**Dose (if known)**	**How often do you take them?**	**Start Date**	**End Date**	**What are they for?**
Now or in the past 6 months, have you taken any prescribed medications for emotional or behavioral symptoms?				**Yes**	**No**
Have the medications helped you feel better?				**Yes**	**No**
In what ways have they helped?					
In the past 6 months have you had any bad side effects from these medications?				**Yes**	**No**
What were the bad side effects?					

Over the counter medications, herbs, vitamins, or supplements:				
Medication, herb, vitamin, or supplement	**Dose (if known)**	**How often do you take them?**	**Start Date**	**What are they for?**
Do you have trouble taking medications as prescribed?	**Do not have to take medicine**	**Always as prescribed**	**Sometimes as prescribed**	**Seldom as prescribed**
Do you want help with this?			**Yes**	**No**
Other treatments that you are receiving (counseling, psychotherapy, OT, PT, chiropractor, acupuncture, traditional healing, other):				

Health History							
Condition/Behavior			If present, how much are you bothered by this condition/ behavior?			Would you like to talk about his with your provider?	
Do you have or have you ever had: (circle Past and Present if ongoing)							
ADHD	Past	Present	Yes	A little	No	Yes	No
AIDS/HIV	Past	Present	Yes	A little	No	Yes	No
Alcohol abuse	Past	Present	Yes	A little	No	Yes	No
Anxiety	Past	Present	Yes	A little	No	Yes	No
Any heart problems or heart murmur	Past	Present	Yes	A little	No	Yes	No
Any other significant problems	Past	Present	Yes	A little	No	Yes	No
Any primary current skin problem (acne, eczema)	Past	Present	Yes	A little	No	Yes	No
Appendicitis	Past	Present	Yes	A little	No	Yes	No
Anemia or bleeding problem	Past	Present	Yes	A little	No	Yes	No
Arthritis	Past	Present	Yes	A little	No	Yes	No
Asthma, bronchitis, bronchiolitis, pneumonia	Past	Present	Yes	A little	No	Yes	No
Autism	Past	Present	Yes	A little	No	Yes	No
Bedwetting	Past	Present	Yes	A little	No	Yes	No
Bipolar disorder	Past	Present	Yes	A little	No	Yes	No
Bladder or kidney infection	Past	Present	Yes	A little	No	Yes	No
Blood transfusion	Past	Present	Yes	A little	No	Yes	No
Cancer	Past	Present	Yes	A little	No	Yes	No
Carpal tunnel	Past	Present	Yes	A little	No	Yes	No
Cataracts	Past	Present	Yes	A little	No	Yes	No
Chickenpox	Past	Present	Yes	A little	No	Yes	No
Constipation requiring doctor visits	Past	Present	Yes	A little	No	Yes	No
Convulsions or neurological problems	Past	Present	Yes	A little	No	Yes	No
Depression	Past	Present	Yes	A little	No	Yes	No
Developmental/ Intellectual Disability	Past	Present	Yes	A little	No	Yes	No
Diabetes	Past	Present	Yes	A little	No	Yes	No
Dizziness	Past	Present	Yes	A little	No	Yes	No
Drug abuse	Past	Present	Yes	A little	No	Yes	No

Eating disorder	Past	Present	Yes	A little	No	Yes	No
Fainting	Past	Present	Yes	A little	No	Yes	No
Frequent abdominal pain	Past	Present	Yes	A little	No	Yes	No
Frequent ear infections	Past	Present	Yes	A little	No	Yes	No
Frequent headaches	Past	Present	Yes	A little	No	Yes	No
Gallbladder disease	Past	Present	Yes	A little	No	Yes	No
Glaucoma	Past	Present	Yes	A little	No	Yes	No
Gout	Past	Present	Yes	A little	No	Yes	No
Hallucinations	Past	Present	Yes	A little	No	Yes	No
Headache	Past	Present	Yes	A little	No	Yes	No
Hearing problems	Past	Present	Yes	A little	No	Yes	No
Hepatitis (A, B, C)	Past	Present	Yes	A little	No	Yes	No
Hernia	Past	Present	Yes	A little	No	Yes	No
Herpes	Past	Present	Yes	A little	No	Yes	No
High blood pressure (hypertension)	Past	Present	Yes	A little	No	Yes	No
Kidney disease	Past	Present	Yes	A little	No	Yes	No
Liver disease	Past	Present	Yes	A little	No	Yes	No
Low blood pressure (hypotension)	Past	Present	Yes	A little	No	Yes	No
Lung disease	Past	Present	Yes	A little	No	Yes	No
Measles	Past	Present	Yes	A little	No	Yes	No
Mumps	Past	Present	Yes	A little	No	Yes	No
Mental illness	Past	Present	Yes	A little	No	Yes	No
Mental retardation	Past	Present	Yes	A little	No	Yes	No
Nasal allergies	Past	Present	Yes	A little	No	Yes	No
Neurological disorder	Past	Present	Yes	A little	No	Yes	No
Obesity or been Overweight	Past	Present	Yes	A little	No	Yes	No
Pacemaker	Past	Present	Yes	A little	No	Yes	No
Physical abuse	Past	Present	Yes	A little	No	Yes	No
Pneumonia	Past	Present	Yes	A little	No	Yes	No
Polio	Past	Present	Yes	A little	No	Yes	No
Problems with eyes or vision	Past	Present	Yes	A little	No	Yes	No
Legal blindness	Past	Present	Yes	A little	No	Yes	No
Problems with ears or hearing	Past	Present	Yes	A little	No	Yes	No
Rheumatic fever	Past	Present	Yes	A little	No	Yes	No
Sexual abuse	Past	Present	Yes	A little	No	Yes	No
Sexually transmitted disease	Past	Present	Yes	A little	No	Yes	No

Shingles	Past	Present	Yes	A little	No	Yes	No
Sleep problems	Past	Present	Yes	A little	No	Yes	No
Stomach problems	Past	Present	Yes	A little	No	Yes	No
Stroke	Past	Present	Yes	A little	No	Yes	No
Suicide attempt	Past	Present	Yes	A little	No	Yes	No
Thyroid or other endocrine problems	Past	Present	Yes	A little	No	Yes	No
Tobacco use	Past	Present	Yes	A little	No	Yes	No
Tuberculosis	Past	Present	Yes	A little	No	Yes	No
Ulcers	Past	Present	Yes	A little	No	Yes	No
Urinary problems/incontinence/wetting self	Past	Present	Yes	A little	No	Yes	No
Use of alcohol or drugs	Past	Present	Yes	A little	No	Yes	No
Violent or aggressive behaviors	Past	Present	Yes	A little	No	Yes	No
Wandering or running away	Past	Present	Yes	A little	No	Yes	No
Condition/Behavior-Do you have or have you ever had: (circle Past and Present if ongoing)							
Problems with teeth						Yes	No
Problems with gums						Yes	No
Difficulty chewing						Yes	No
Difficulty swallowing						Yes	No
Appetite change last six months						Yes	No
Weight loss						Yes	No
Weight gain						Yes	No
Women's Health							
Period started at age							
Number of pregnancies							
Number of live births							
Number of miscarriages							
Do you have or have you ever had:							
Birth Control						Yes	No
If yes, which one							
Hysterectomy						Yes	No
PAP						Yes	No
If yes, indicated date of your PAP				_ _/_ _/_ _ _ _		Don't know	
Mammogram						Yes	No
If yes, indicated date of mammogram				_ _/_ _/_ _ _ _		Don't know	

Men's Health			
Penis discharge		Yes	No
Sore on penis		Yes	No
Erectile dysfunction		Yes	No
Testicular lump		Yes	No
Vasectomy		Yes	No
PSA	_ _/_ _/_ _ _ _	Yes	No
Prostrate problems		Yes	No
Prostate exam	_ _/_ _/_ _ _ _	Yes	No

E.R. Visits	
Date	Reason

Surgeries	
Date	Reason

Substance Abuse Treatments	
Date	Reason

Sexual Activity		
Are you using a method to prevent pregnancy?	Yes	No
If so, which types (condoms, pills, Depo shot, patch, Nexplanon/Implanon, foam, sponge, withdrawal, ring, IUD etc.)?		

Immunizations				
Up to date?	Yes	No	Don't know/ Not Sure	Refused
During the past 12 months have you had either a flu shot or a flu vaccine that was sprayed into your nose?	Yes	No	Don't know/ Not Sure	Refused
A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime, and is different from the flu shot. Have you ever had a pneumonia shot?	Yes	No	Don't know/ Not Sure	Refused

Have you ever had the shingles or zoster vaccine?	Yes	No	Don't know/ Not Sure	Refused
Please indicate any of the following immunizations you have received:				
Chicken Pox	Yes	No	Don't know/ Not Sure	Within last 10 years
DTaP (diptheria, tetanus, acellular pertussis; 5 doses at 2, 4 6, 15 -18 mo & 4-6 yrs; <7 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
Influenza (annual dose beginning at 6 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hepatitis A (2 doses; and 18-23 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hepatitis B (3 doses, birth, 1 to 2 mo & 6 to 18 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hib (Haemophilus influenzae type b; 4 doses at 2, 4, 12 or 15 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
HPV (Human Papilloma Virus; ages 11 to 26 females; ages 11 to 21 males)	Yes	No	Don't know/ Not Sure	Within last 10 years
IPV (Inactivated poliovirus; 4 doses ; 2, 4, 6 -18 mos & 4-6 yrs; <18 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
MMR (measles, mumps rubella; 2 doses 12-15 mos & 4-6 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
Meningococcal (2 doses; 11-12 yrs and booster 16-18 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
PCV13 (Pneumococcal conjugate; 4 doses at 2, 4, 6, 12 or 15 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Shingles	Yes	No	Don't know/ Not Sure	Within last 10 years
Td/Tdap (Tetanus, diphtheria, pertussis; 11 to 12 yrs; 10 yr boosters)	Yes	No	Don't know/ Not Sure	Within last 10 years

Hospitalizations	
Date	**Reason**

Health Concerns		
Specific Health Concerns - I would like to talk with or get help from my healthcare provider		
Accident or injury prevention	**Yes**	**No**
Ear, eye or mouth care	**Yes**	**No**
Exercise and nutrition	**Yes**	**No**
Health screening tests	**Yes**	**No**
Money, housing case management	**Yes**	**No**
Living will, end-of-life issues	**Yes**	**No**
Long term care needs	**Yes**	**No**
Family or personal problems	**Yes**	**No**
Depression or other mental concerns	**Yes**	**No**
Preventing cancer	**Yes**	**No**
Preventing heart disease	**Yes**	**No**
Problems with my healthcare	**Yes**	**No**
Other	**Yes**	**No**

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Clinical Screen

Over the last two weeks, how often have you been bothered by any of the following problems? (please check your answer and circle the boxes that apply to you)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Felling down, depressed, or hopeless	0	1	2	3
☐ Thoughts that you would be better off dead or, ☐ Hurting yourself in some way	0	1	2	3
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

Standard serving of one drink:
12 ounces of beer or wine cooler
1.5 ounces of 80 proof liquor
5 ounces of wine
4 ounces of brandy, liqueur or aperitif

Please circle your answer

How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month, you:

Have had nightmares about it or thought about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

Anxiety Screen				
Over the last two weeks, how often have you been bothered by any of the following problems? (please circle your answer)				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Worrying too much about different things	**0**	**1**	**2**	**3**
Trouble relaxing	**0**	**1**	**2**	**3**
Being so restless that it is hard to sit still	**0**	**1**	**2**	**3**
Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
Feeling afraid, as if something awful might happen	**0**	**1**	**2**	**3**

Audit-10					
Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking. **These questions are about your drinking habits. We've listed the serving size of one drink below.**					
Standard serving of one drink: **12 ounces of beer or wine cooler** **1.5 ounces of 80 proof liquor** **5 ounces of wine** **4 ounces of brandy, liqueur or aperitif**					
Please circle your answer					
How often do you have one drink containing alcohol?	**Never**	**Monthly or less**	**2-4 times a month**	**2-3 times a week**	**4+ times a week**
How many drinks containing alcohol do you have on a typical day when you are drinking?	**1 or 2**	**3 or 4**	**5 or 6**	**7 to 9**	**10 or more**
How often do you have four or more drinks on one occasion?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
How often during the last year have you…					
found that you were not able to stop drinking once you had started?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
failed to do what was normally expected from you because of drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
needed a first drink in the morning to get yourself going after heavy drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
had a feeling of guilt or remorse after drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**

been unable to remember what happened the night before you had been drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
Have you or someone else been injured as a result of your drinking?	**No**	**Yes, but not in the last year**			**Yes, during the last year**
Has a relative, friend, doctor, or health worker been concerned about your drinking or suggested you cut down?	**No**	**Yes, but not in the last year**			**Yes, during the last year**
The Columbia Scale (C-SSRS)					
In the past month					
Have you wished you were dead or wished you could go to sleep and not wake up?				**Yes**	**No**
Have you actually had any thoughts about killing yourself?				**Yes**	**No**
If you answered Yes to 2, answer 3,4,5, and 6. If you answered No to 2, go directly to question 6.					
Have you thought about how you might do this?				**Yes**	**No**
Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?				**Yes**	**No**
Have you started to work out or worked out details of how to kill yourself?				**Yes**	**No**
Do you intend to carry out this plan?				**Yes**	**No**
In the past 3 months					
Have you done anything, started to do anything, or prepared to do anything to end your life? ***Examples: Collected pills, obtained a gun, given away valuables, wrote a will or suicide note, took put pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.***				**Yes**	**No**
In your entire lifetime, how many times have you done any of these things?					
Depression Survey					
Over the last two weeks, how often have you been bothered by any of the following problems? (please check your answer and <u>circle the boxes that apply to you</u>)					
	Not at all	**Several days**	**More than half the days**	**Nearly every day**	
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**	
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**	
☐ **Trouble falling or staying asleep or,** ☐ **Sleeping too much**	**0**	**1**	**2**	**3**	
Feeling tired or having little energy	**0**	**1**	**2**	**3**	
☐ **Poor appetite or,** ☐ **Overeating**	**0**	**1**	**2**	**3**	

	Not at all	Several days	More than half the days	Nearly every day
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
☐ Moving or speaking so slowly that other people could have noticed or, ☐ The opposite-being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
☐ Thoughts that you would be better off dead or, ☐ Hurting yourself in some way	0	1	2	3

PC-PTSD		
In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month, you:		
Have had nightmares about it or thought about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

Adult Member Information		
Background		
What brought you in for services today?		
Would you like an interpreter?	Yes	No
Do you have a developmental/intellectual disability?	Yes	No
If Yes, do you have an Individual Service Plan related to your developmental/intellectual disability?	Yes	No
Do you have an Emergency Crisis Plan? (if yes, please provide a copy)	Yes	No
Were you referred?	Yes	No
If yes, by whom were you referred?		
Nursing Facility Level of Care (NFLOC)?		
Height and Weight		
Height (in inches)		
Weight (in pounds)		
Exam Dates		
Date of last physical exam	_ _/_ _/_ _ _ _	Don't Know
Date of last dental exam	_ _/_ _/_ _ _ _	Don't Know
Date of last vision exam	_ _/_ _/_ _ _ _	Don't Know
Date of last hearing exam	_ _/_ _/_ _ _ _	Don't Know
Date of last bone density exam	_ _/_ _/_ _ _ _	Don't Know

Care Team				
Care Coordinator				
Name				
Primary Care Provider				
Name				
Phone Number (###-###-####)				
Behavioral Health Therapist				
Name				
Phone Number (###-###-####)				
Plan of Care				
Short-term Goals; 0-3 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Short-term Goals; 0-3 Months				
Goal				
Intervention				
Progress				

Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Long-term Goals; 3-12 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Long-term Goals; 3-12 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Self Management Goals				
Goal				

Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Self Management Goals				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _
Future Opportunities				
Demographics/Psychosocial				
Name of person filling out assessment				

Relationship of person filling out assessment to the person coming in today	**Self**	**Parent/ Guardian**	**Friend**	**Other**
If Other please describe				

Are there cultural or religious preferences that you would like your provider to be aware of today?	**Yes**	**No**	**Prefer not to answer**
If Yes please describe			

General Health Information						
Are you currently in any physical pain?					Yes	No
How much pain are you in today? Please enter best response, with 0 being no pain and 10 being the most pain you have ever had.						
Where is your pain?						
Have you ever had a traumatic brain injury (head injury, concussion)?					Yes	No
Do you need help with transportation to appointments?					Yes	No
In general, would you say your physical health is:	Excellent	Very Good	Good	Fair	Poor	Prefer not to answer
In general, would you say your mental health is:	Excellent	Very Good	Good	Fair	Poor	Prefer not to answer
Have you had any psychiatric hospitalization in the last 6 months?				Yes	No	Prefer not to answer
Are you currently taking atypical psychotropic medications, such as Ability, Clozaril, Zyprexa, Seroquel, Risperdal, or Geodon?				Yes	No	Prefer not to answer
How much are you bothered by medication side effects (for example, shaking and trembling, not being able to think clearly, gaining or losing weight, or sexual problems)?	Not bothered at all	Bothered a little	Bothered moderately	Bothered a lot	Prefer not to answer	

Diagnosis
Diagnosis

Member Goals
Member Goals

Home Life		
How may people live in your home, including you?		
Who lives in your home with you? (circle all that apply)		
Mother	Stepmother	Father
Stepfather	Two Mothers	Two Fathers
Mother's boyfriend	Father's girlfriend	Boyfriend/partner
Girlfriend/partner	Spouse/Partner's Mother or Father	Grandmother(s)
Grandfather(s)	Aunt(s)	Uncle(s)
Cousin(s)	Foster Parent(s)	Friend(s)
Other Relative(s)	Pet(s)	None of these apply

What is your current living arrangement? (circle one)	
Homeless	Dependent Living
Dependent Living: Residential Care	Dependent Living: Foster Care/Foster Home
Dependent Living: Crisis Residence	Dependent Living: Institutional Setting
Dependent Living: Jail/Correctional Facility/Other Institutions Under the Justice System	Dependent Living: Private Residence

Independent Living				Unknown	Private Residence, Living Arrangement not Specified			
Have you been homeless at any time in the last 6 months?						Yes	No	Prefer not to answer
Are you having any problems at home? (circle all that apply)								
Violence			Money			Fighting		
House			Food			Gas		
Electricity			Water			Cooling		
You are out of work			Spouse/Partner out of work			Substance use of others		
Concerns with a family member			Do not have any of these problems					
Would you like to discuss this with someone?						Yes	No	Prefer not to answer
Current Providers								
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Resources								
Community Resources and Services Being Utilized								
Resource					Service (circle all that apply)			
Income Support Division								
Medicaid	CHIP	SNAP	TEFAP	TANF	GA	RRS	LIHEAP	CSBG
Behavioral Health Services Division (BHSD)								
Mental Illness Treatment					Substance Abuse Treatment			
Aging and Long Term Services Department (ALTSD)								
Consumer and Elder Rights Division (CERD) Assistance					Aging Network Division (AND) Assistance			
Child Support Enforcement Services (CSES)								
Paternity Establishment					Collection/Enforcement			
Children Youth and Families (CYFD)								
Early Childhood Services			Protective Services			Juvenile Justice Services		
Department of Health (DOH)								
Immunizations					WIC			
Religious Organization								
Emergency Housing (Short Term/Transitional)			Emergency Food			Other		
Section 8 Housing								
Section 8 Housing								

Needed Community Resources and Services								
Resource					Service (circle all that apply)			
Income Support Division								
Medicaid	CHIP	SNAP	TEFAP	TANF	GA	RRS	LIHEAP	CSBG
Behavioral Health Services Division (BHSD)								
Mental Illness Treatment					Substance Abuse Treatment			
Aging and Long Term Services Department (ALTSD)								
Consumer and Elder Rights Division (CERD) Assistance					Aging Network Division (AND) Assistance			
Child Support Enforcement Services (CSES)								
Paternity Establishment					Collection/Enforcement			
Children Youth and Families (CYFD)								
Early Childhood Services			Protective Services			Juvenile Justice Services		
Department of Health (DOH)								
Immunizations					WIC			
Religious Organization								
Emergency Housing (Short Term/Transitional)			Emergency Food			Other		
Section 8 Housing								
Section 8 Housing								
Disaster Plan								
Disaster Preparedness Plan								
Adult Health & Well-Being								
Health Behaviors								
In the past three months have you smoked cigarettes or used any form of tobacco (e.g. chew, dip, cigars, hookah and/or e-cigarettes)?							Yes	No
Have you ever ridden in a car driven by someone (including yourself) that was high or was using alcohol or drugs?							Yes	No
Does anyone in your home take opioids for an ongoing medical condition ? (OxyContin, Hydrocodone, Codeine)							Yes	No
Do you lock your opioid medications in a medicine cabinet or other locked location?							Yes	No
Do you have a smoke detector in your home?							Yes	No
Do you have gas heating or appliances in your home?							Yes	No
Do you have carbon monoxide detector in your home?							Yes	No
Caregiver								
Do you have a caregiver that comes into the home, because of a health care problem, to provide you with assistance?							Yes	No
Is caregiver a relative, friend or from an agency?						Relative	Friend	Agency
Caregive/Agency Name								
Caregive/Agency phone number (###-###-####)								

Caregive/Agency Specialty				
How many hours per day/week does caregiver come into your home? **(☐ per day, or ☐ per week)**				
What items does your caregiver help with?				
Do you need more help than you are receiving?			**Yes**	**No**
Please explain:				
ADL/IADL				
Please indicate your ability to do the activities in the table below. **If you are Receiving Help for any of these, indicate Yes or No,**				
Bathing				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Dressing				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Grooming				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Mouth care				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Toileting				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Transferring bed/chair				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Walking				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Climbing Stairs				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Eating				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Shopping				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Cooking				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	

Manging medications				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Using phone book/ looking up numbers				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Doing housework				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Doing laundry				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Driving or using public transportation				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Managing finances				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	

Sleep				
On average how many hours of sleep do you get in a 24 hour period				
Do you feel your sleep is restful?			**Yes**	**No**

Employment			
What is your current type of employment?			
Employed-Full time	**Employed-Part time**	**Not employed, but seeking employment**	
Not employed, not seeking employment	**Not in labor force (e.g. retired, disabled, homemaker, student, volunteer**	**Prefer not to answer**	
If not employed (circle all that apply):			
I am in the the process of seeking benefits or I don't want to risk losing my benefits	**I worry that my symptoms will interfere with my work**	**I'm not sure how to go about getting a job**	
Not applicable	**Other**	**Prefer not to answer**	
If employed, how many hours do you work per week			

Durable Medical Equipment				
Air-fluidized beds and other support surfaces	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Bar in toilet/shower	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Blood sugar (glucose) test strips	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Blood sugar monitors	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Canes (however, white canes for the blind aren't covered)	**Have**	**Want**	**Wish to discuss**	**Don't Need**

Commode chairs	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Continuous passive motion (CPM) machine	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Crutches	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Eyeglasses/contacts	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Hearing aid or other hearing equipment	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Hospital beds	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Infusion pumps and supplies (when necessary to administer certain drugs)	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Manual wheelchairs and power mobility devices	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Nebulizers and nebulizer medications	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Oxygen equipment and accessories	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Patient lifts	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Shower bench	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Suction pumps	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Traction equipment	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Translation devices	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Walkers	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Wheelchair	**Have**	**Want**	**Wish to discuss**	**Don't Need**
Do you have other adaptive equipment that is not listed above?			**Yes**	**No**
If yes, please describe:				
Do you want other adaptive equipment that is not listed above?			**Yes**	**No**
If yes, please describe:				

Legal					
Do you have an advance directive and/or living will?			Yes	No	Don't Know
Do you have a copy of your advance directive and/or living will to put in your record?				Yes	No
Do you have a psychiatric advance directive?			Yes	No	Don't Know
Do you have a copy of your advance directive and/or living will to put in your record?				Yes	No
Have you given Power of Attorney (POA) to someone?				Yes	No
If yes, who?					
Do you have a copy of your POA to put in your record?				Yes	No
In the past six months, have you been arrested?	Yes	No	Don't know	Prefer not to answer	Not applicable
In the past six months, were you the victim of any violent crimes, such as assault, rape,	Yes	No	Don't know	Prefer not to answer	Not applicable
Safety/Injuries					
Do you have a gun/firearm in the home?				Yes	No
If yes, is it unloaded?				Yes	No
If yes, is it locked up?				Yes	No
During the past 12 months did you smoke any marijuana or hashish?				Yes	No
During the past 12 months did you use anything else to get high (includes illegal drugs, over-the-counter and prescription drugs, and things you sniff or huff?				Yes	No
Please answer the following if you answered yes to either of the last two questions above. Otherwise, leave the following blank.					
Do you use drugs to relax, feel better about yourself or fit in?				Yes	No
Do you ever use drugs while you're by yourself, alone?				Yes	No
Have you ever gotten into trouble while you were using drugs?				Yes	No
Do you ever forget things you did while using drugs?				Yes	No
Does your family or friends ever tell you that you should cut down on your drug use?				Yes	No
Client Concerns					
What are your future plans for work, career and family goals?					
Financial Support					
In the past six months, did you generally have enough money each month to cover food?				Yes	No
In the past six months, did you generally have enough money each month to cover clothing?				Yes	No
In the past six months, did you generally have enough money each month to cover housing?				Yes	No

In the past six months, did you generally have enough money each month to cover traveling around to get things, shopping, medical appointments, or visiting friends or relatives?	Yes	No
In the past six months, did you generally have enough money each month to cover social activities like movies or eating in restaurants?	Yes	No
In the past six months, did you generally have enough money each month to cover Heating, air conditioning, water, electricity, gas?	Yes	No
Have you received mental health or developmental disability services?	Yes	No
Do you have questions you would like to discuss with your provider?	Yes	No
Do you know what benefits are available to you?	Yes	No
Do you feel your benefits meet your needs?	Yes	No
Clinical Summary		
Allergies		
Medication allergies	Yes	No
If yes, what are they?		
Food allergies	Yes	No
If yes, what are they?		
Environmental allergies (hay fever, dust, etc.)	Yes	No
If yes, what are they?		
Pharmacy Name		
Pharmacy Location		
Pharmacy phone number (###-###-####)		

Current Medications

Medication	Dose (if known)	How often do you take them?	Start Date	What are they for?

Previous medications: Only list atypical anti-psychotics from the following: Risperdal (Risperidone), Seroquel (Quetiapine), Geodon (Ziprasidone), Zyprexa (Olanzapine), Invega (Paliperidone), Saphiris (Asenipine), Clozaril (Clozapine), Abilify (Aripiprazole), Latuda (Lurasidone), Vraylar (Cariprazine), Rexulti (brexpiprazole)					
Medication	**Dose (if known)**	**How often do you take them?**	**Start Date**	**End Date**	**What are they for?**
Now or in the past 6 months, have you taken any prescribed medications for emotional or behavioral symptoms?				**Yes**	**No**
Have the medications helped you feel better?				**Yes**	**No**
In what ways have they helped?					
In the past 6 months have you had any bad side effects from these medications?				**Yes**	**No**
What were the bad side effects?					

Over the counter medications, herbs, vitamins, or supplements:				
Medication, herb, vitamin, or supplement	**Dose (if known)**	**How often do you take them?**	**Start Date**	**What are they for?**
Do you have trouble taking medications as prescribed?	**Do not have to take medicine**	**Always as prescribed**	**Sometimes as prescribed**	**Seldom as prescribed**
Do you want help with this?			**Yes**	**No**
Other treatments that you are receiving (counseling, psychotherapy, OT, PT, chiropractor, acupuncture, traditional healing, other):				

Health History							
Condition/Behavior			If present, how much are you bothered by this condition/ behavior?			Would you like to talk about his with your provider?	
Do you have or have you ever had: (circle Past and Present if ongoing)							
ADHD	Past	Present	Yes	A little	No	Yes	No
AIDS/HIV	Past	Present	Yes	A little	No	Yes	No
Alcohol abuse	Past	Present	Yes	A little	No	Yes	No
Anxiety	Past	Present	Yes	A little	No	Yes	No
Any heart problems or heart murmur	Past	Present	Yes	A little	No	Yes	No
Any other significant problems	Past	Present	Yes	A little	No	Yes	No
Any primary current skin problem (acne, eczema)	Past	Present	Yes	A little	No	Yes	No
Appendicitis	Past	Present	Yes	A little	No	Yes	No
Anemia or bleeding problem	Past	Present	Yes	A little	No	Yes	No
Arthritis	Past	Present	Yes	A little	No	Yes	No
Asthma, bronchitis, bronchiolitis, pneumonia	Past	Present	Yes	A little	No	Yes	No
Autism	Past	Present	Yes	A little	No	Yes	No
Bedwetting	Past	Present	Yes	A little	No	Yes	No
Bipolar disorder	Past	Present	Yes	A little	No	Yes	No
Bladder or kidney infection	Past	Present	Yes	A little	No	Yes	No
Blood transfusion	Past	Present	Yes	A little	No	Yes	No
Cancer	Past	Present	Yes	A little	No	Yes	No
Carpal tunnel	Past	Present	Yes	A little	No	Yes	No
Cataracts	Past	Present	Yes	A little	No	Yes	No
Chickenpox	Past	Present	Yes	A little	No	Yes	No
Constipation requiring doctor visits	Past	Present	Yes	A little	No	Yes	No
Convulsions or neurological problems	Past	Present	Yes	A little	No	Yes	No
Depression	Past	Present	Yes	A little	No	Yes	No
Developmental/ Intellectual Disability	Past	Present	Yes	A little	No	Yes	No
Diabetes	Past	Present	Yes	A little	No	Yes	No
Dizziness	Past	Present	Yes	A little	No	Yes	No
Drug abuse	Past	Present	Yes	A little	No	Yes	No

Eating disorder	Past	Present	Yes	A little	No	Yes	No
Fainting	Past	Present	Yes	A little	No	Yes	No
Frequent abdominal pain	Past	Present	Yes	A little	No	Yes	No
Frequent ear infections	Past	Present	Yes	A little	No	Yes	No
Frequent headaches	Past	Present	Yes	A little	No	Yes	No
Gallbladder disease	Past	Present	Yes	A little	No	Yes	No
Glaucoma	Past	Present	Yes	A little	No	Yes	No
Gout	Past	Present	Yes	A little	No	Yes	No
Hallucinations	Past	Present	Yes	A little	No	Yes	No
Headache	Past	Present	Yes	A little	No	Yes	No
Hearing problems	Past	Present	Yes	A little	No	Yes	No
Hepatitis (A, B, C)	Past	Present	Yes	A little	No	Yes	No
Hernia	Past	Present	Yes	A little	No	Yes	No
Herpes	Past	Present	Yes	A little	No	Yes	No
High blood pressure (hypertension)	Past	Present	Yes	A little	No	Yes	No
Kidney disease	Past	Present	Yes	A little	No	Yes	No
Liver disease	Past	Present	Yes	A little	No	Yes	No
Low blood pressure (hypotension)	Past	Present	Yes	A little	No	Yes	No
Lung disease	Past	Present	Yes	A little	No	Yes	No
Measles	Past	Present	Yes	A little	No	Yes	No
Mumps	Past	Present	Yes	A little	No	Yes	No
Mental illness	Past	Present	Yes	A little	No	Yes	No
Mental retardation	Past	Present	Yes	A little	No	Yes	No
Nasal allergies	Past	Present	Yes	A little	No	Yes	No
Neurological disorder	Past	Present	Yes	A little	No	Yes	No
Obesity or been Overweight	Past	Present	Yes	A little	No	Yes	No
Pacemaker	Past	Present	Yes	A little	No	Yes	No
Physical abuse	Past	Present	Yes	A little	No	Yes	No
Pneumonia	Past	Present	Yes	A little	No	Yes	No
Polio	Past	Present	Yes	A little	No	Yes	No
Problems with eyes or vision	Past	Present	Yes	A little	No	Yes	No
Legal blindness	Past	Present	Yes	A little	No	Yes	No
Problems with ears or hearing	Past	Present	Yes	A little	No	Yes	No
Rheumatic fever	Past	Present	Yes	A little	No	Yes	No
Sexual abuse	Past	Present	Yes	A little	No	Yes	No
Sexually transmitted disease	Past	Present	Yes	A little	No	Yes	No

Shingles	Past	Present	Yes	A little	No	Yes	No
Sleep problems	Past	Present	Yes	A little	No	Yes	No
Stomach problems	Past	Present	Yes	A little	No	Yes	No
Stroke	Past	Present	Yes	A little	No	Yes	No
Suicide attempt	Past	Present	Yes	A little	No	Yes	No
Thyroid or other endocrine problems	Past	Present	Yes	A little	No	Yes	No
Tobacco use	Past	Present	Yes	A little	No	Yes	No
Tuberculosis	Past	Present	Yes	A little	No	Yes	No
Ulcers	Past	Present	Yes	A little	No	Yes	No
Urinary problems/incontinence/wetting self	Past	Present	Yes	A little	No	Yes	No
Use of alcohol or drugs	Past	Present	Yes	A little	No	Yes	No
Violent or aggressive behaviors	Past	Present	Yes	A little	No	Yes	No
Wandering or running away	Past	Present	Yes	A little	No	Yes	No
Condition/Behavior-Do you have or have you ever had: (circle Past and Present if ongoing)							
Problems with teeth						Yes	No
Problems with gums						Yes	No
Difficulty chewing						Yes	No
Difficulty swallowing						Yes	No
Appetite change last six months						Yes	No
Weight loss						Yes	No
Weight gain						Yes	No
Women's Health							
Period started at age							
Number of pregnancies							
Number of live births							
Number of miscarriages							
Do you have or have you ever had:							
Birth Control						Yes	No
If yes, which one							
Hysterectomy						Yes	No
PAP						Yes	No
If yes, indicated date of your PAP				_ _/_ _/_ _ _ _		Don't know	
Mammogram						Yes	No
If yes, indicated date of mammogram				_ _/_ _/_ _ _ _		Don't know	

Men's Health			
Penis discharge		Yes	No
Sore on penis		Yes	No
Erectile dysfunction		Yes	No
Testicular lump		Yes	No
Vasectomy		Yes	No
PSA	_ _/_ _/_ _ _ _	Yes	No
Prostrate problems		Yes	No
Prostate exam	_ _/_ _/_ _ _ _	Yes	No

E.R. Visits	
Date	Reason

Surgeries	
Date	Reason

Substance Abuse Treatments	
Date	Reason

Sexual Activity		
Are you using a method to prevent pregnancy?	Yes	No
If so, which types (condoms, pills, Depo shot, patch, Nexplanon/Implanon, foam, sponge, withdrawal, ring, IUD etc.)?		

Immunizations				
Up to date?	Yes	No	Don't know/ Not Sure	Refused
During the past 12 months have you had either a flu shot or a flu vaccine that was sprayed into your nose?	Yes	No	Don't know/ Not Sure	Refused
A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime, and is different from the flu shot. Have you ever had a pneumonia shot?	Yes	No	Don't know/ Not Sure	Refused

Have you ever had the shingles or zoster vaccine?	Yes	No	Don't know/ Not Sure	Refused
Please indicate any of the following immunizations you have received:				
Chicken Pox	Yes	No	Don't know/ Not Sure	Within last 10 years
DTaP (diptheria, tetanus, acellular pertussis; 5 doses at 2, 4 6, 15 -18 mo & 4-6 yrs; <7 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
Influenza (annual dose beginning at 6 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hepatitis A (2 doses; and 18-23 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hepatitis B (3 doses, birth, 1 to 2 mo & 6 to 18 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hib (Haemophilus influenzae type b; 4 doses at 2, 4, 12 or 15 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
HPV (Human Papilloma Virus; ages 11 to 26 females; ages 11 to 21 males)	Yes	No	Don't know/ Not Sure	Within last 10 years
IPV (Inactivated poliovirus; 4 doses ; 2, 4, 6 -18 mos & 4-6 yrs; <18 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
MMR (measles, mumps rubella; 2 doses 12-15 mos & 4-6 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
Meningococcal (2 doses; 11-12 yrs and booster 16-18 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
PCV13 (Pneumococcal conjugate; 4 doses at 2, 4, 6, 12 or 15 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Shingles	Yes	No	Don't know/ Not Sure	Within last 10 years
Td/Tdap (Tetanus, diphtheria, pertussis; 11 to 12 yrs; 10 yr boosters)	Yes	No	Don't know/ Not Sure	Within last 10 years

Hospitalizations	
Date	**Reason**

Health Concerns		
Specific Health Concerns - I would like to talk with or get help from my healthcare provider		
Accident or injury prevention	**Yes**	**No**
Ear, eye or mouth care	**Yes**	**No**
Exercise and nutrition	**Yes**	**No**
Health screening tests	**Yes**	**No**
Money, housing case management	**Yes**	**No**
Living will, end-of-life issues	**Yes**	**No**
Long term care needs	**Yes**	**No**
Family or personal problems	**Yes**	**No**
Depression or other mental concerns	**Yes**	**No**
Preventing cancer	**Yes**	**No**
Preventing heart disease	**Yes**	**No**
Problems with my healthcare	**Yes**	**No**
Other	**Yes**	**No**

APPENDIX W

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APPENDIX Y

Healthy Lifestyle Questionnaire

Date: ___/___/_____ MRN: _____

Name: _____ DOB: ___/___/____ Phone:( )_____

Medicaid recipient ☐ yes ☐no What is the primary language spoken in your home? _____

Please help us give you the best possible healthcare. The following questions are about things that can affect your health, and knowing about it can be important in providing you with the best medical care. Your provider will talk to you about your answers.
This information will be kept strictly confidential unless you are at risk of serious harm. Thank you!

Please answer the following:

During the past two weeks:		
1. Have you often been bothered by feeling down, depressed, or hopeless?	No	Yes
2. Have you often been bothered by little interest or pleasure in doing things?	No	Yes
--For Staff Use--	0 **Dep =**	1 x ___
During the past two weeks:		
3. Have you often been bothered by feeling nervous, anxious or on edge?	No	Yes
4. Have you often been bothered by not being able to stop or control worrying?	No	Yes
--For Staff Use--	0 **Anx =**	1 x ___

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, during the past month, you:		
5. Have had nightmares about it or thought about it when you did not want to?	No	Yes
6. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
7. Were constantly on guard, watchful, or easily startled?	No	Yes
8. Felt numb or detached from others, activities, or your surroundings?	No	Yes
--For Staff Use--	0 **PTS =**	1 x ___

The following 3 questions are about your drinking during the past year. A drink is equal to a 12 oz. beer, a 5 oz. glass of wine, or 1.5 oz. liquor.					
9. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per mon	2-3 times per week	4+ times per week
10. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 to 2	3 or 4	5 or 6	7 to 9	10 or more
11. How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
--For Staff Use--	0	1 x ___=___	2 x ___=___	3 x __=___	4 x ___=___
The following questions are about your use of other substances.				**A =____**	

12. In the last year have you used Cannabis Products (marijuana, grass, hashish, etc.)?	No	Yes
12a. If yes, do you have a medical prescription for this use?	No	Yes
--For Staff Use— sub total (+1 for use (12) and -1 for MM (12a), 0 for No)		
13. In the last year have you used any of the following substances-not prescribed to you: -AMPHETAMINES (meth, speed, Adderall, diet pills); -COCAINE (coke, crack); -INHALANTS (nitrous oxide, glue, paint, paint thinner); -OPIATES (heroin, hydrocodone, oxycontin, oxycodone, morphine, methadone, codeine); -HALLUCINOGENS (LSD, acid, ecstasy, mushrooms, PCP, special K); - BENZODIAZEPINES (RITALIN, VALIUM, XANAX, KLONOPIN/CLONAZEPAM)	No	Yes
--For Staff Use—	0 **D =**	1

Thank you for taking the time to complete this form.

Revised 10/11/2018

FOR STAFF USE ONLY

SCREENING POSITIVE FOR SBIRT MEANS SBIRT SERVICES INDICATED

CLIENT SCORES & CLIENT CLASSIFICATION
(Not the services provided)

Below please indicate the client's scores:				
Depression: _____	Anxiety: _____	PTSD:_____	Alcohol:_____	Drug:_____
Brief Intervention	**Brief Treatment**		**Referral to Treatment**	
☐	☐		☐	

Screen Scoring Instructions

QUESTIONS #'S	DESCRIPTION	SCORING INSTRUCTIONS
1-2	Depression	**Positive score = ≥ 1** (score one point for each yes answer) **Score ≥ 1 = BI**
3-4	Anxiety	**Positive score = ≥ 1** (score one point for each yes answer) **Score ≥ 1 = BI**
5-8	PTSD	**Positive score = ≥3** (score one point for each yes answer) **Score ≥3 = BI**
9-11	Alcohol	**Positive score is ≥3 (for either gender)** Answers score 0 Points for column one; 1 point for column two; 2 points for column three; 3 points for column four; and 4 points for column five. Tally scores accordingly. **Score 3-4= BI, Score 5-9= BT, Score 10-12= RT**
12-13	Drug Use	**Positive Score** = ≥ 1 (score one point for each yes answer, except for 12a). For item 12 score one point for yes answer. For 12a, score -1 for yes answer. For 13 score one point for yes answer. Tally scores accordingly. **Score +1 for Cannabis= BI, Score +1 for substance other than cannabis= BT**

Note: Score=1 for drug and score=3-9 for alcohol= BT

Cuestionario Respecto a la Salud y la Vida

Fecha: ___/___/___ MRN:_____

Nombre del paciente: _____Fecha de nacimiento:___/___/__ Telefono:_____

Tiene Medicaid ☐ yes ☐no Idioma principal que se habla en casa?_____

Ayúdenos a darle la mejor asistencia médica posible. El uso del alcohol y las drogas afecta su salud y al saber los detalles de su consumo, podemos brindarle un mejor servicio de salud. Su proveedor de salud hablará con usted sobre sus respuestas. ***Esta información es estrictamente confidencial a menos que usted ponga su vida en alto riesgo. ¡Muchas Gracias!***

Por favor responder a lo siguiente:

Durante las últimos dos semanas :		
1. ¿Se ha molestado frecuentemente porque se ha sentido desanimado, deprimido o sin esperanza?	No	Sí
2. ¿Se ha sentido molesto frecuentemente debido al poco interés o placer en hacer las cosas?	No	Sí
--Para uso oficial--	**0 1x__ Humor=**	
Durante las últimas dos semanas:		
3. ¿Ha sentido sensaciones de nerviosismo, ansiedad o a punto de ansiedad?	No	Sí
4. ¿Ha sentido molestia porque no puede controlar sus preocupaciones?	No	Sí
--Para uso oficial--	**0 1x__ Ansiedad=**	
Durante su vida ha tenido alguna experiencia tan espantosa, horroroso, o desagradable que le ha causado algunos de estos síntomas en el último mes, usted:		
5. ¿Ha tenido pesadillas o ha pensado en la experiencia cuando no quería?	No	Sí
6. ¿Ha tratado de no pensar en la experiencia o se ha complicado la vida para evadir una situación que se acordó sobre la experiencia?	No	Sí
7. ¿Esta siempre en guardia, preocupado, molesto o se asusta fácilmente?	No	Sí
8. ¿Se ha sentido desanimado, frio o separado de otras personas, actividades, o sus alrededores?	No	Sí
- -Para uso oficial- -	**0 1x__ Trauma=**	

Las siguientes preguntas son sobre su uso del alcohol durante el último año. Una bebida es igual a una cerveza (12 onzas), un vaso de vino (5 onzas), o un trago de licor (1.5 onzas).					
9. ¿Con que frecuencia toma una bebida alcohólica?	Nunca	Una vez o menos por mes	2-4 veces por mes	2-3 por semana	4+ por semana
10. ¿Cuantas bebidas alcohólicas toma durante un día típico?	0 -2	3-4	5-6	7-9	Más de 10
11. ¿Con que frecuencia toma, 6 bebidas o más en una ocasión?	Nunca	Menos que una vez por mes	Mensual	semanal	Diario o casi diario
--Para uso oficial--	0	1 x ___=___	2 x ___=___	3 x ___=___	4 x ___=___
Las siguientes preguntas son sobre su uso de otras drogas.					**A =___**

12. ¿Durante el ultimo año ha usado productos de Cannabis (marihuana, mota, hachis) ¿ --- 12.a. Si si, ¿tiene usted una receta médica para este uso?	No No	Si Si
--Para uso oficial-- sub-total (+1 uso (12) y -1 para MM (12a), 0 para No)		
13. **Durante el último año**, ¿Ha usado alguna sustancia en esta lista de manera no-prescrita? • ANFETAMINAS (meth, anfetas, Adderall, pastillas para perder peso); • COCAÍNA (chiva, crack); • INHALANTES (óxido nitroso, goma, pintura, adelgazador de pintura); • OPIATAS (heroína, hydrocodone, oxycontin, oxycodone, morfina, metadona, codeína); • ALUCINÓGENOS (LSD, ácido, éxtasis, hongos psilocibios, PCP [fenciclidina], ketamina); • Benzodiazepinas (Ritalin, Valium, Xanax, Clonazepam/Clonopin)	No	Sí
14. ¿Ha usado medicamentos recetados de manera no-prescrita?	No	Sí
--Para uso oficial--	**0 1 D = __**	

Gracias por tormarse el tiempo para completar este formulario.

FOR STAFF USE ONLY

SCREENING POSITIVE FOR SBIRT MEANS SBIRT SERVICES INDICATED

CLIENT SCORES & CLIENT CLASSIFICATION
(Not the services provided)

Below please indicate the client's scores:				
Depression: _____	Anxiety: _____	PTSD:_____	Alcohol:_____	Drug:_____
Brief Intervention	**Brief Treatment**		**Referral to Treatment**	
☐	☐		☐	

Screen Scoring Instructions

QUESTIONS #'S	DESCRIPTION	SCORING INSTRUCTIONS
1-2	Depression	**Positive score = ≥ 1** (score one point for each yes answer) **Score ≥ 1 = BI**
3-4	Anxiety	**Positive score = ≥ 1** (score one point for each yes answer) **Score ≥ 1 = BI**
5-8	PTSD	**Positive score = ≥3** (score one point for each yes answer) **Score ≥3 = BI**
9-11	Alcohol	**Positive score is ≥ 3 (for either gender)** Answers score 0 Points for column one; 1 point for column two; 2 points for column three; 3 points for column four; and 4 points for column five. Tally scores accordingly. **Score 3-4= BI, Score 5-9= BT, Score 10-12= RT**
12-13	Drug Use	**Positive Score** = ≥ 1 (score one point for each yes answer, except for 12a). For item 12 score one point for yes answer. For 12a, score -1 for yes answer. For 13 score one point for yes answer. Tally scores accordingly. **Score +1 for Cannabis= BI, Score +1 for substance other than cannabis= BT**

Note: Score=1 for drug and score=3-9 for alcohol= BT

APPENDIX Z

Drug Abuse Screening Test, DAST-10

NAME: _____ DATE: _____

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over□the□counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you unable to stop abusing drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?

Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.

Interpretation of Score

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re□assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Alcohol Screen (AUDIT)

NAME: _____ DATE: _____

Please help us give you the best possible healthcare. The following questions are about things that can affect your health and knowing about it can be important in providing you with the best medical care. Your provider will talk to you about your answers.
This information will be kept strictly confidential unless you are at risk of serious harm. **Thank you!**

Please answer the following:

The following questions are about your drinking during the past year. A drink is equal to a 12 oz. beer, a 5 oz. glass of wine, or 1.5 oz. liquor.

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?
4. How often have you found that you were not able to stop drinking once you started?
5. How often have you failed to do what was normally expected of you because of your drinking?
6. How often have you needed a first drink in the morning to get yourself going after a heavy drinking session?
7. How often have you had a feeling of guilt or remorse after drinking?
8. How often have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested that you cut down?

APPENDIX ZB

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks , how often have you been bothered by any of the following problems?

1. Little interest or pleasure doing things
2. Feeling down, depressed or hopeless
3. Trouble fallilng or stalying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor apetite or overeating
6. Feeling bad about yoursef - or that you are a failure or have let yourself or family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could notice. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
9. Thought that you would be better off dead, or of huring yourself
10. Feeling afraid as if something awful might happen

APPENDIX ZC

PCL-C

NAME: _____ DATE: _____

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

1.	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	
2.	Repeated, disturbing dreams of a stressful experience from the past?	
3.	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	
4.	Feeling very upset when something reminded you of a stressful experience from the past?	
5.	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	
6	Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it?	
7.	Avoiding activities or situations because they reminded you of a stressful experience from the past?	
8.	Trouble remembering important parts of a stressful experience from the past?	
9.	Loss of interest in activities that you used to enjoy?	
10.	Feeling distant or cut off from other people?	
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?	
12.	Feeling as if your future will somehow be cut short?	
13.	Trouble falling or staying asleep?	
14.	Feeling irritable or having angry outbursts?	
15.	Having difficulty concentrating?	
16.	Being "super-alert" or watchful or on guard?	
17.	Feeling jumpy or easily startled?	

GAD-7

NAME: _____ DATE: _____

Over the last 2 weeks, how often have youbeen bothered by the following problems?

1. Feeling nervous, anxious or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

APPENDIX ZE

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APPENDIX ZF

New Mexico Behavioral Health Collaborative

Brent Earnest— Co-Chair Monique Jacobson — Co-Chair
Wayne Lindstrom—CEO

INTENSIVE OUTPATIENT PROGRAM (IOP)
PROVIDER ATTESTATION STATEMENT

(Name of the agency) agrees to abide by the following requirements for certification as an IOP Provider.

- An Intensive Outpatient Program (IOP) provides a time-limited, multi-faceted approach to treatment service for individuals who require structure and support to achieve and sustain recovery.
- IOP services are provided through an integrated multi-disciplinary approach includes staff expertise in both addiction and mental health treatment.
- IOP should address substance use disorders as well as co-occurring mental health disorders when indicated.
- IOP Services are provided to children, age 13-17 who have been diagnosed with a substance abuse disorder or with a co-occurring disorder (mental illness and substance abuse); or, meet the American Society of Addiction Medicine (ASAM) patient placement criteria for Level 2.1.
- IOP Services utilize Evidence-Based Practice (EBPs) models only and will insure fidelity to that standard with evidence that supports it success in IOP.
- IOP Services reflect cultural sensitivity and a trauma-informed approach and provides the policy and procedures demonstrating how that is implemented.
- IOP Services are delivered by a multi-disciplinary team.
- IOP Services comply with the definition of Intensive Outpatient Services per SAMSHA and State of New Mexico Medicaid guidelines.
- IOP Services are delivered by appropriately trained and credentialed professionals who have specialized skills in the EBP model being utilized and who meet licensure requirements including scope of practice per state licensing. Documentation demonstrates appropriate training and certification.

- The IOP Clinical Supervisor meets all of the requirements in accordance with licensing board regulations as defined in Medicaid regulation 8.310.15.10, Section E.

- The agency has an IOP evaluation system in place and provides evidence of same.
- The agency has and maintains the appropriate state facility licensure (DOH, CYFD) as applicable.

- All prospective clients will have a treatment file from an appropriate practitioner or agency that contains at least a diagnostic evaluation and an individualized treatment plan that includes IOP as an intervention.

- All current clients have the required standard documentation for outpatient services according to NMAC 8.321.2.

- The agency will comply with the New Mexico Children's Mental Health Code statutes related to Mandatory Child Abuse and Neglect reporting by all certified Child/Youth CCSS providers and all Children's Rights and age-specific Consent for Services statutes.

- Any agency serving adolescents will complete CYFD approved background checks on all employees.

My signature below verifies agreement with all of the requirements detailed in this attestation and I further understand that failure to comply with these may lead to sanction and recoupment of funding.

_____ _____

Signature of authorized agency representative Witness Initials

_____ _____

Date Date

New Mexico Behavioral Health Collaborative

Brent Earnest— Co-Chair Monique Jacobson — Co-Chair

Wayne Lindstrom—CEO

INTENSIVE OUTPATIENT

CERTIFICATION TOOL

	STAFF DOCUMENTS	P	F	Provider Response	BHSD Finding
1	Provide a complete roster of IOP clinical supervisor(s) and program staff along with program organization chart.				
2	Provide IOP clinical supervisor and program staff job descriptions.				
3	Provide verification that clinical supervisor(s) meets licensing board standards and IOP requirements to deliver clinical supervision. Documentation of 1 year supervision experience and 2 years IOP experience prior to becoming IOP clinical supervisor. Documentation as MAD approved provider.				
4	Provide copies of agency employee performance evaluation tool and the clinical supervision form.				
5	Provide program treatment schedule(s)/ calendar(s), if applicable for EBP.				
6	Provide copy of treatment plan form.				
7	Provide copy of program evaluation form.				
8	Provide copy of psycho-social assessment/diagnostic evaluation form.				
9	Provide copy of medication form if applicable.				
Client treatment program					
10	Provide policy and procedure that outlines how clients are assessed for eligibility.				

	STAFF DOCUMENTS	P	F	Provider Response	BHSD Finding
11	Provide policy and procedure that outlines the treatment planning process including discharge planning. Include guidelines that clearly specify how treatment planning is related to clients' goals and objectives. Specify the process for evaluating time-limited services. Discuss how 90-day treatment plan review will occur.				
12	Provide policy and procedure that outlines how the provision and integration of mental health and substance abuse services are managed to include co-occurring disorders. Include in this policy how IOP will integrate with other services at the agency.				
13	Provide policy(ies) and procedure that support recovery and resiliency values, cultural sensitivity, gender informed care, and trauma-informed practices.				
14	Provide policy and procedure on how medication services are managed, in-house or through referral process. Include protocols.				
15	Provide policy and procedure on drug screen protocols if applicable. Include form used.				
16	Provide policy and procedure that addresses crisis management including the crisis/safety planning process. Include referral process.				
Program structure					
17	Provide policy and procedure that clearly outlines the EBP model utilized and how this model will be evaluated according to fidelity standards. Describe how deficiencies will be addressed. Include process for assessing treatment/program outcomes.				

	STAFF DOCUMENTS	P	F	Provider Response	BHSD Finding
18	Provide policy and procedure that specifically supports an integrated multidisciplinary team. Include frequency of scheduled team meetings and members of the team.				
Supervision					
19	Provide policy procedure that specifies how the agency assesses supervisory requirements for clinical supervision, particularly in the areas of co-occurring and substance use skill/training. Address state and program requirements. Include how supervision is provided to include frequency and number of hours and how this is documented and how deficits in training/practice are identified and addressed in a time-limited manner for both the supervisor and the supervisee.				
Program specific and agency training					
20	Provide policy and procedure that clearly outlines the process for insuring that all IOP treatment staff have been adequately trained in the EBP model. Describe how staff will receive ongoing training as needed and how skill level of trainers is evaluated.				
21	Provide policy and procedure that describes how program staff are trained in culturally sensitive and trauma-based approaches, crisis management and safety techniques, critical incident reporting, HIPAA, agency records management and record keeping protocols, and ethics to include conflict of interest.				

	For adolescent services, provide policy and procedure to demonstrate they will conform to New Mexico Children's Code NMSA 1978 32A-1-1 et Seq statutes and associated New Mexico Children's Code definitions. Specifically: 1) Mandatory Child Abuse and Neglect reporting 2) Children's Rights and age-specific Consent for Services statutes				
	For adolescent services, provide policy and procedure to demonstrate their compliance with background checks for all employees. Background checks must conform to 8.8.3 NMAC Background Check Unit background clearances and pre-hiring processes as well as 7.20.11.15.A-H NMAC Criminal Records Checks and Clearances regulatory requirements.				
	For adolescent services, provide policy and procedure to explain how adolescent treatment is developmentally appropriate and is youth and family centric and youth driven.				
	For adolescent services, provide policy and procedure which demonstrates treatment planning and assessments are all trauma informed.				

New Mexico Behavioral Health Collaborative

Brent Earnest— Co-Chair Monique Jacobson — Co-Chair

Wayne Lindstrom—CEO

INTENSIVE OUTPATIENT PROGRAM CERTIFICATION INFORMATION

Service Description:

Intensive Outpatient Program services provide a time-limited, multi-faceted approach to treatment for eligible recipients who require structure and support to achieve and sustain recovery. The IOP model is based on research and evidence-based interventions that target specific behaviors with individualized behavioral interventions.

Services are culturally-sensitive and incorporate recovery and resiliency values into all service interventions. Services address co-occurring mental health disorders, as well as substance use disorders, when indicated. Treatment is provided through an integrated multi-disciplinary team and services. Core services include individual therapy, group therapy (membership to not exceed 15 in number) and psycho-education to the recipient and his/her family.

The duration of IOP treatment services is typically three to six months; the amount of weekly services is dependent upon the goals and objectives outlined in the recipient's treatment plan. Medication management may be part of the Intensive Outpatient Program.

PLEASE REFER TO MEDICAID REGULATIONS TITLE 8 SOCIAL SERVICES, CHAPTER 321.2 HEALTH CARE PROFESSIONAL SERVICES, PART 17 INTENSIVE OUTPATIENT PROGRAM SERVICES for further information.

Purpose of application/certification & attestation:

The intent of the Behavioral Health Service Division IOP application process is to insure that all requirements under Medicaid regulations are met for clinical provision of this level of service. Particular focus is on fidelity to the model, program evaluation, clinical supervision, and clinical service provision to program recipients.

Process:

The agency must be a Medicaid approved provider and meet the criteria for agency/facility type as listed on the application page of this packet.

1. The agency will complete the application for Intensive Outpatient Program form and the IOP Provider Attestation Statement.
2. The provider will review and submit all documents requested in the IOP Certification Tool to: hsd.csmbhsd@state.nm.us – **subject line IOP**. Upon receipt of the application and requested documents, the packet will be assigned for review and acknowledgment of receipt will be sent to the provider via email.

3. The provider will be contacted by the BHSD reviewer with further questions or requests for information.
4. Once the packet has passed all requirements, the provider will be notified of the proposed site visit date.
5. Once the site visit is complete and all documents are in order, a letter of clinical certification will be provided and sent to the Medicaid Assistance Division.

Additional requirements:

All providers rendering services for Medicaid eligible recipients must have acquired a Medicaid ID through Conduent/MAD enrollment process and have an active NPI number through the National Plan & Provider enumeration System (NPPES).

APPENDIX ZI

New Mexico Behavioral Health Collaborative

Brent Earnest— Co-Chair Monique Jacobson — Co-Chair

Wayne Lindstrom—CEO

APPLICATION FOR INTENSIVE OUTPATIENT PROGRAM

Provider Information:

Agency Name: _____

Agency Address: _____

Mailing Address (if different): _____

Executive Director Name: _____

Contact Person: _____

Contact Phone Number: _____

Contact Email Address: _____

IOP Office Locations: _____

_____

_____

Services provided to (check all that apply):

___ Adults, age 18 and over

___ Children, age 13-17

Agency Type:

___ Community Mental Health Center (CMHC)
___ MAD CSA
___ Federally Qualified Health Center (FQHC)
___ Indian Health Services (IHS)
___ PL. 93-638 Tribal Facility
___ Agency approved by MAD to meet IOP program requirements

Agency Medicaid Enrollment ID: _____

Agency NPI: _____
Date completed: _____

APPENDIX ZJ

Intensive Outpatient Program

Site Visit Preparation Form

Materials needed prior to site visit:

- ☐ List of clients for the last 6 months (unique identifiers)
- ☐ List of all staff who work within or attached to IOP
- ☐ MAD approval letter
- ☐ Performance Evaluations of staff implementing IOP
- ☐ Copy of licensure of staff providing and supporting IOP
- ☐ Proof of EBP training for staff implementing IOP
- ☐ Evidence of Cultural Competence training for staff providing and supporting IOP
- ☐ Table of organization of IOP Service Team (Treatment Team)

IOP Supervisor only

- ☐ Proof of working in IOP or equivalent 2 years and 1 year of being a supervisor prior to becoming supervisor
- ☐ Documentation showing training for supervising in EBP

Quality Assurance

- ☐ QA documentation specific to EBP and fidelity to the EBP
- ☐ Documentation of QA Meetings 2 x per year
- ☐ Client satisfaction/Outcomes reporting and documentation

Additional material to be reviewed on site;

Personnel Files

- ☐ Personnel Files
- ☐ Copy of Licensure
- ☐ MAD provider approval letter

- ☐ Proof of EBP specific training
- ☐ Supervision records
- ☐ Cultural competency training documentation
- ☐ Performance Evaluations

Selected Client Files

Psychiatric Evaluation Including

- ☐ ASAM criteria
- ☐ Dynamics of Co-occurring disorder
- ☐ Risk Assessment
- ☐ Strengths

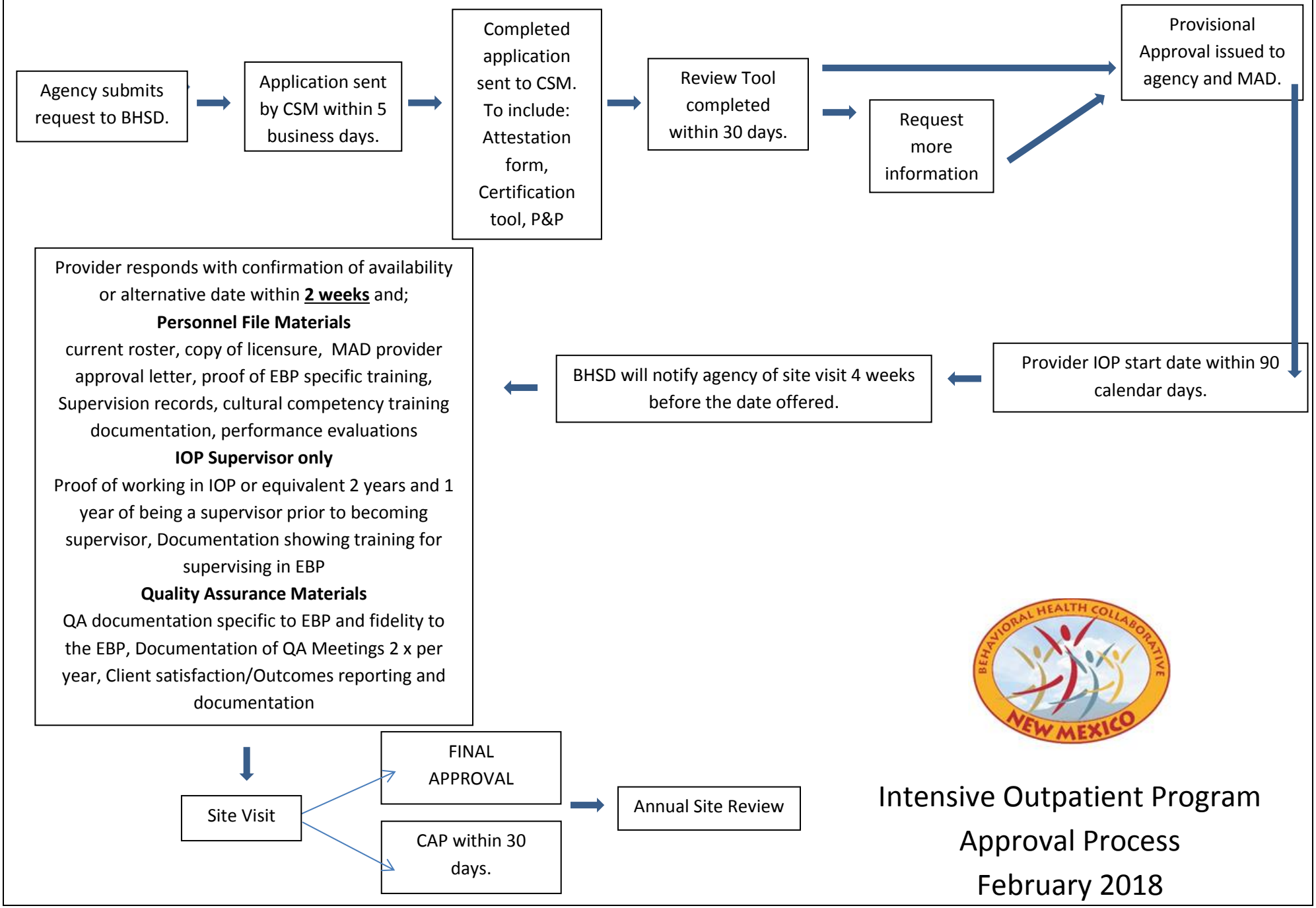
Treatment Plan Including

- ☐ Goals/Interventions for each problem in the evaluation
- ☐ Created at start of treatment
- ☐ Updated every 90 days
- ☐ Signed by client and therapist
- ☐ Include family supports
- ☐ Reflect development level of client
- ☐ Take culture into account
- ☐ Concrete goals that support recovery

- ☐ Evidence of multi-disciplinary team
- ☐ Integration of other services at agency
    1. Examples: MAT, CCSS
- ☐ Progress notes
- ☐ Cultural competence, awareness, curiosity
- ☐ Trauma Informed Care/ Responses
- ☐ Relapse and/or Crisis Plan
- ☐ Release of information when appropriate
- ☐ Client Bill of Rights
- ☐ Grievance Procedures
- ☐ Treatment schedule
- ☐ Evidence of EBP Fidelity in treatment documentation
- ☐ Evidence of golden thread running from assessment, treatment plan, notes to discharge
- ☐ Urinalysis and Breathalyzer results, if appropriate for EBP

BHSD staff will pull random staff files for review. They will also want to interview staff who have different roles within the agency and are a part of IOP.

APPENDIX ZK



Intensive Outpatient Program Approval Process

February 2018

Intensive Outpatient Programs: Site Visit Tool

Provider information

Agency Name: _____

Physical Address: _____
City State Zip

If applying for multiple sites or applying to serve adolescents and/or adults please note and list specific physical locations:

_____
City State Zip

_____
City State Zip

_____
City State Zip

_____
City State Zip

Mailing Address (if different than above) for each site:

_____ City
State Zip

_____
City State Zip

Website: _____

Provider Contact Information for Responsible Party Completing Application:

Name/Title: _____

Email Address: _____

Office Phone: _____ Mobile Phone: _____

Mailing Address: _____
City State Zip

IOP Services are Provided to: (8.310.15.12 Eligible Recipients)

☐ ***Adults, age 18 and over***: IOP services are provided to adults aged 18 years and over diagnosed with substance abuse disorders or with co-occurring disorders (serious mental illness and substance abuse) or that meet the American Society of Addiction Medicine (ASAM) patient placement criteria for level two (II) - intensive outpatient treatment.

☐ ***Youth in Transition***, ages 18-21 years

Youth, 13-17 years: IOP services are provided to youth, aged 13-17 years, diagnosed with substance abuse disorders or with co-occurring disorders (serious emotional disturbance and substance abuse) or that meet the American Society Of Addiction Medicine (ASAM) patient placement criteria for level two (II) - intensive outpatient treatment.

Intensive Outpatient Programs: Site Visit Tool

This Agency is a:

- ☐ Community Mental Health Center (CMHC)
- ☐ Rural Health Clinic (RHC)
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Indian Health Services (IHS) Facility
- ☐ PL.93-638 Tribal Facility
- ☐ An agency requesting approval from BHSD submitting the documentation necessary to demonstrate that the agency meets all requirements of an intensive outpatient program services and supervision requirements

Onsite Feedback:

Areas of Strength:
Opportunities for Growth:

Intensive Outpatient Programs: Site Visit Tool

All items listed in **bold-faced, underlined text** in the "Assessment Criteria" column are **pass/fail**. The Provider must demonstrate that these items have been adequately supported in the documents submitted in their application. If any one of these items fails, then the application as a whole fails. It is MAD's intent that upon approval of this application, the Provider will implement their MAD IOP program in accordance with the approved policies and procedures as submitted. The use of the clinical practice standards, evidence-based practices, and the most current Service Definition provide guidance to the Provider of the information necessary to be approved as a MAD IOP provider. The Provider must comply with all sections of MAD 8.310.15 NMAC, Intensive Outpatient Services rule.

If the Provider is operating multiple sites, the responses, documents, policies/procedures must specifically address how the agency will coordinate and collaborate between the sites. In particular, how staffing, supervision, and training will be managed. Each site will be individually provisionally and fully approved and visited.

If the Provider is proposing to serve both adolescents and adults, the application must specifically detail the uniqueness of each population in its policies/procedures, documents and responses.

A. Quality Management Documentation				
Item	**Assessment Criteria**	**Yes ✓**	**No ✓**	**Comments**
B. IOP providers are required to develop and implement a program evaluation system. *(8.310.15.10-F)*	**1. Does the provider have an IOP-specific program evaluation (quality management) to be utilized?** **Through Interview**	1. ☐	1. ☐	
	2. Can the Clinical Director describe and show you how the IOP program will track fidelity to the model?	2. ☐	2. ☐	2.
	2a. Is there evidence demonstrating that the model is being followed?	2a. ☐	2a. ☐	2a.
	3. Are there quality management meetings that are regularly scheduled?	3. ☐	3. ☐	3.
	3a. Is there evidence demonstrating that	3a. ☐	3a.☐	3a.

Intensive Outpatient Programs: Site Visit Tool

	the meetings are regularly scheduled and held?			
	4. Can the provider describe how the IOP-specific program evaluation system will be used to track and/or evaluate client outcomes?	4. ☐	4. ☐	4.
	4a. Is there evidence of program evaluation? (There may be customer satisfaction surveys, retention into service rates, drop-out rates, re-admittance/relapse and lapse rates, incarceration or hospitalization data, or readily identifiable information and data specific to the IOP that may be contained in the quality management reports.)	4a☐	4a. ☐	4a.
	5. Description of how program success will be measured, such as demographics of recipients served; effects on the utilization of criminal justice system by enrolled recipients; changes in recipient employment; numbers and reasons why recipients did not complete IOP program.	5. ☐	5. ☐	5.
	5a. Is there evidence of measurement of success?	5a. ☐	5a. ☐	5a.
	6. How this information is internally analyzed concerning client satisfaction and client beliefs of the effectiveness	6. ☐	6. ☐	6.

Intensive Outpatient Programs: Site Visit Tool

	of services. 6a. Is there evidence of analysis and client voice? 7. How are findings from the analysis integrated/implemented by the agency? 7a. Is there evidence of integration/ implementation of analysis findings?	6a. ☐ 7. ☐ 7a. ☐	6a. ☐ 7. ☐ 7a. ☐	6a. 7. 7a.
A3. Research-based model specific to IOP services (8.310.15.14-F) IOP services must be rendered through a research-based model: (1) Matrix Model Adult Treatment Model (2) Matrix Model Adolescent Treatment Model (3) Minnesota Treatment Model (4) Integrated Dual Disorder Treatment (5) 7 Challenges (6) Other authorized G. Services not provided in accordance with the conditions for coverage as specified in 8.327.0.10 and 8.327.0.14 NMAC, Intensive Outpatient Program Services, are not considered covered services and are subject to recoupment.	**1a. Is the provider monitoring fidelity to the chosen model as evidenced in their QA?** **1b. Do the client files show fidelity through scheduled groups and individual therapy?**	1a. ☐ 1b. ☐ .	1a. ☐ 1b. ☐	1a. 1.b

Intensive Outpatient Programs: Site Visit Tool

B. Supervision				
Item	**Assessment Criteria**	**Yes ✓**	**No ✓**	**Comments**
D1. Each IOP program must have a clinical supervisor. The clinical supervisor may also serve as the IOP program supervisor. Both clinical services and supervision by licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the requirements listed in column 2, # 1. (8.310.15.10-E)	1 . Does the Clinical Supervisor have: **a. An active licensure as an independent practitioner?** b. Two years relevant experience with IOP eligible recipients c. One year documented supervisory experience d. If b &c are not present was an exceptions request filed and approved? e. Education, formal, or staff development in both mental health and substance abuse treatment **f. Has formal training been completed for EBP IOP & supervisory curriculum?** **2. Specific to the agency IOP program – In the employee record, are there supervision forms:** **a. that reflect follow-up from previous meetings** **b. that document planned training and follow-up those trainings were attended and improvements made in performance**	1a. ☐ 1b. ☐ 1c. ☐ 1d.☐ 1e. ☐ 1f. ☐ 2a. ☐ 2b. ☐	1a. ☐ 1b.☐ 1c.☐ 1d.☐ 1e.☐ 1f.☐ 2a. ☐ 2b.☒	1a. 1b. 1c. 1d. 1e. 1f. 2a. 2b.

Intensive Outpatient Programs: Site Visit Tool

B. Supervision				
	c. schedule of individual supervision dates and time	2c. ☐	2c. ☐	2c.
	3. Is there evidence of all forms requiring supervisory review being countersigned by the Supervisor?	3. ☐	3. ☐	3.

Intensive Outpatient Programs: Site Visit Tool

C. Personnel Files				
Item		**Yes ✓**	**No ✓**	**Comments**
E1. Services must be culturally-sensitive and incorporate recovery and resiliency values into all service interventions. *(8.310.15.13)*	**1. Ongoing employee training plan that specifically includes relevant opportunities for staff to learn more about IOP model fidelity and compliance**	1. ☐	1. ☐	1.
	2. Training on how to handle potentially disruptive or unruly client behavior.	2. ☐	2. ☐	2.
	3. Does the provider have the forms that demonstrate that recovery and resiliency values are embedded in the job descriptions and administrative and supervisory guidelines?	3. ☐	3. ☐	3.
	4. Does the provider have training plans that cover recovery and resiliency values for IOP staff?	4. ☐	4. ☐	4.
	5. Does the provider have training plans that cover cultural competency for IOP staff?	5. ☐	5. ☐	5.
	6. Does the provider have documentation that the agency has a plan to match linguistic needs of the community served when hiring?	6. ☐	6. ☐	6.

Intensive Outpatient Programs: Site Visit Tool

C. Personnel Files				
E2. ELIGIBLE PROVIDERS: Services must be provided within the scope of the practice and licensure for each provider and must be in compliance with the statutes, rules and regulations of the applicable practice act and must be eligible for reimbursement as described in 8.310.8B-E NMAC Behavioral Health Professional Services. (8.310.15.10-E)	**1. Is there evidence that IOP clinicians have active New Mexico licensure that matches the scope of services they are providing?** 2. Is there evidence of education, formal training, or staff development specific to co-occurring disorders for IOP clinicians? (Note: training can include staff development and/or training from clinical supervisor.) **3. IOP clinicians are trained in EBP IOP curriculum in compliance with State of NM MAD Rule? (training may be conducted in-house by supervisory staff who have attended formal EBP training)** 4. Is there evidence that staff are receiving COD, EBP, and other appropriate training as indicated by their supervisor?	1. ☐ 2. ☐ 3. ☐ 4. ☐	1. ☐ 2. ☐ 3. ☐ 4. ☐	1. 2. 3. 4.
E3. Documents that must be provided by agency if applying for enrollment as an IOP agency requesting approval from MAD.	**1. Are there Employee Performance Evaluations for each IOP program staff?**	1. ☐	1.☐	1.

Intensive Outpatient Programs: Site Visit Tool

D. Client Files				
Item	**Assessment Criteria**	**Yes ✓**	**No ✓**	**Comments**
F1a **8.310.15.12 ELIGIBLE RECIPIENTS:** A. IOP services are provided to youth, aged 13-17 years, diagnosed with substance abuse disorders or with co-occurring disorders (serious emotional disturbance and substance abuse) or that meet the American society of addiction medicine (ASAM) patient placement criteria for level two (II). F1b. IOP services are provided to adults aged 18 years and over diagnosed with substance abuse disorders or with co-occurring disorders (serious mental illness and substance abuse) or that meet the ASAM patient placement criteria for level two (II) - intensive outpatient treatment. *(See next row for a list of ASAM criteria)* F2. ASAM: Levels of Care: *(8.310.15.12-A)* Level 0.5: Early Intervention Services - Individuals with problems or risk factors related to substance use, but for whom an	**1. Is there evidence that each client meets the eligibility criterion of ASAM level II.1 services: IOP services or diagnosed with substance abuse disorders or with co-occurring disorders as specified by the diagnostician documented in Assessment (H0031-U8) or a Diagnostic/Evaluation (90801) or other diagnostic evaluation as approved by the Medical Assistance Division that is current, (within 12 months) completed, signed and dated by a licensed clinician under the supervision of a licensed Independent Clinician?** **(If files show evidence of II.4 or higher, initiate a conversation about 1) why, including what services are or are not available; 2) if there are additional risk management protocols in place for the case.)** **2. Is there evidence that the level of care is specified in the individualized**	1. ☐	1. ☐	1.

Intensive Outpatient Programs: Site Visit Tool

D. Client Files				
immediate substance -related disorder cannot be confirmed Opioid Maintenance Therapy (OMT) - Criteria for Level I Outpatient OMT, but OMT in all levels Level I Outpatient Treatment Level II.1 Intensive Outpatient Treatment Level II.5 Partial Hospitalization Level III.1 Clinically-Managed, Low Intensity Residential Treatment Level III.3 Clinically-Managed, Medium Intensity Residential Treatment (Adult Level only) Level IV Medically-Managed Intensive Inpatient Treatment	**service plan? This should include what domains of service were identified in the Assessment/Diagnostic evaluation appropriate to IOP services.**	2. ☐	2. ☐	2.
F3. Before engaging in an IOP program, the eligible recipient must have a treatment file that contains a diagnostic evaluation and an individualized service plan that includes IOP as an intervention. *(8.310.15.12-C)* Individual case files contain evidence of culturally-sensitive and recovery and resiliency-based treatment. *(8.310.14.13)*	**1. Is there evidence that the Individual Service Plan will address all issues identified in the Assessment/Diagnostic evaluation appropriate to IOP services?** **2. Is there evidence that co-occurring disorders are assessed for addressed?** 3. Is there evidence of a relapse and/or crisis plan (may be the same document)? 4. Is there evidence of for progress notes for each treatment session including: • IOP services, and/or • individual counseling, and/or • psycho-ed? 5. Is there evidence that all other	1. ☐ 2. ☐ 3. ☐ 4. ☐ 5.☐	1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐	1 2. 3. 4. 5.

Intensive Outpatient Programs: Site Visit Tool

D. Client Files				
	domains of service identified in the assessment/evaluation have been addressed in the service plan?			
	6. Is there evidence that the consumer and/or parent/guardian, as appropriate, identify and agree to specific, personal goals of treatment, and signed documents appropriately?	6. ☐	6. ☐	6.
	7. <u>Is there evidence that Releases of Information specific to treatment needs are in the record where appropriate?</u>	7. ☐	7. ☐	7.
	8. Is there evidence that the Client Bill of Rights was signed and located in the client's chart?	8. ☐	8. ☐	8.
	9. Is there evidence that of MDT feedback in the client record?	9. ☐	9. ☐	9.
	10. Is there evidence of treatment schedule/attendance document?	10. ☐	10.☐	10.
	11. Is there evidence that the time of service each week aligns with the recommended EBP service intensity specific to client needs and capability as documented in the Assessment (H0031-U8) or a Diagnostic/Evaluation (90801) or other diagnostic evaluation as approved by the Medical Assistance Division.	11. ☐	11.☐	11.
	12. <u>Is there evidence of a Diagnostic Evaluation (90801) Assessment (H0031-U8) or other diagnostic</u>	12. ☐	12.☐	12.

Intensive Outpatient Programs: Site Visit Tool

D. Client Files				
F4. Medication management services are available to oversee use of psychotropic medications. *(8.310.15.14)*	**evaluation as approved by the Medical Assistance Division is to be current, (within 12 months) stating it must be completed, signed and dated by a licensed clinician under the supervision of a licensed Independent Clinician?** 13. Is there evidence of appropriate assessment for medication, medication management, or referral and follow up for these services?	13.☐	13.☐	13.
F4, Documents that must be provided by agency if applying for enrollment as an IOP agency requesting approval from MAD.	**1. Is there evidence of signed Client rights and grievance procedures that include the Single Entity's and Fee-For-Service (FFS) rights for fair hearings?** **2. Is there evidence of Discharge Planning that:** a. **Is developed at the start of services and is updated as necessary to reflect growth and needs of the consumer.** b. **Is consistent with the treatment plan updates and progress made by the consumer.** c. **Includes family and community support and collaboration.** d. **Reflects the development level and any unique circumstances**	1. ☐ 2. ☐ a. ☐ b. ☐ c. ☐ d. ☐	1. ☐ 2. ☐ a. ☐ b. ☐ c. ☐ d. ☐	1. 2. a. b. c. d.

Intensive Outpatient Programs: Site Visit Tool

D. Client Files				
	for that consumer to continue in recovery. e. **Includes concrete steps that support the consumer in recovery.**	e. ☐	e. ☐	e.
A2. Provision of substance, mental health, or COD services (8.310.15.14-D)	**1. Is there evidence of specific goals/interventions/outcomes for each of the identified problems in the diagnostic evaluation?** **2. Is there evidence of planning for the advent of high risk situations or crises documented in the service or crisis plan?**	1. ☐ 2. ☐	1. ☐ 2. ☐	1. 2.

Intensive Outpatient Programs: Site Visit Tool

D. Client Files				
A4. Treatment services should address co-occurring mental health disorders, as well as substance use disorders, when indicated. (8.310.15.13)	**1. Is there evidence of the psychiatric evaluation containing an integrated summary describing the interactions or the interrelated effects of the disorder dynamic for the co-occurring diagnoses which are to be included in the treatment plan?**	1. ☐	1. ☐	1. .
A5. Services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. (8.310.15.13)	**1. Is there evidence of cultural influences on recovery and resiliency in the record?**	1. ☐	1. ☐	1. .

Intensive Outpatient Programs: Site Visit Tool

D. Client Files				
A7. Documents that must be provided by agency if applying for enrollment as an IOP agency requesting approval from MAD.	**1) <u>Are all documents in the client file signed (and counter-signed when indicated) by the appropriate practitioners?</u>**	1. ☐	1. ☐	1.
	2) <u>Are urinalysis and breathalyzer results documented in the client files?</u>	2. ☐	2. ☐	2.
	3) <u>Are the signed admission forms included in the chart?</u>	3. ☐	3. ☐	3.

<u>Certification –individual(s) completing audit:</u>

Audit Reviewer _____
Print name Date Signature

Audit Reviewer _____
Print name Date Signature

Audit Reviewer _____
Print name Date Signature

Intensive Outpatient Programs: Site Visit Tool

Audit Reviewer _____

Print name Date Signature

Audit Reviewer _____

Print name Date Signature

Audit Reviewer _____

Print name Date Signature

APPENDIX ZM

ACT Readiness and Follow-Up Visit Protocol

Before the Readiness Visit

1. Programs should submit an application for Prior Approval Review

2. A letter should be sent by to the executive director and/or team leader of the ACT program announcing the forthcoming readiness visit. This letter should cover the following:

- Purpose of the visit
- Date, time and expected duration
- Number of visitors
- Program staff that should be available
- Need for a private work area
- Need to notify recipients in advance of the visit so that surveyors can talk with recipients who would like to participate in the survey
- Documentation to be reviewed
- Documentation to be prepared by program for site visit

3. **For follow-up visits**, the letter should request that all charts be available for inspection when the site visitors arrive. In addition, the letter should request the following documentation be prepared by the program in advance of the site visit:

- Personnel documentation
- List of clinical and administrative employees that have left the team in the last two years
- Staffing vacancies
- Staffing hires
- Scheduling documentation
- All intakes by date of admission
- List of consumers with identified substance use disorders
- Attendance sheets for any groups
- Summary of recipient outcomes
- Statistics on discharged recipients for last year
- Minutes from organizational meetings
- Protocol for staff safety in the field
- Curricula from trainings provided in-service or externally
- List of the last 7 consumers that have been hospitalized

4. Visit should be schedule at least one month prior to the expiration of the initial operating license to prevent any possible lapse in the program' certificate

5. Review staff conducting the visit should review the program's Prior Approval Review application

6. Visits should be scheduled when consumers and staff are most available for interviewing

During the Readiness/ Follow-Up Visit

1. Review staff should arrive at the program fully prepared, on time, and with proper identification

2. If a team is used, one reviewer should be designated as team leader and be the spokesperson.

3. The review should begin with a statement of the purpose of the review and a description of how the day will be structured, including the timing and approximate duration of staff and recipient interviews and other activities. It is likely that the first activity will be the observation of the morning team meeting.

4. The following activities, with estimates for their duration, must be completed during the visit:
   - Observation of team morning meeting
   - Interview with team leader
   - Interview with staff member
   - Interview with substance abuse specialist
   - Interview with employment specialist
   - Interview with consumer
   - Review of charts, contact log and completion of worksheets
   - Review of program policies
   - Review of minutes from governing body and incident review
   - Inspection of program site, scheduling tools and safety protocol
   - Scoring of New Mexico ACT Readiness Tool

APPENDIX ZN

General Organizational Index Cover Sheet

Date:_____ Rater(s):

Program Name:

Address:
Contact Person: (Title:)

: Fax:

E-mail:

Sources Used:

____ Chart review ____ Agency brochure review

____ Team meeting observation ____ Supervision observation

____ Interview with Program Director/Coordinator

____ Interview with practitioners ____ Interview with clients

____ Interview with supervisors

____ Interview with rehabilitation service providers

Interview with

Interview with

# of EBP Practitioners: _____ # **of active clients served by EBP:** _____

# of clients served by EBP in preceding year: _____ # of charts reviewed _____

Date program was started:

GOI Score Sheet

Program: _____ Date of Visit:

Informants – Name(s) and Position(s): _____, _____,

_____, _____, _____, _____

Number of Records Reviewed: _____
Rater 1:
Rater 2:
Rater 1 Rater 2 Consensus

G1 Program Philosophy

G2 Eligibility/Client Identification

G3 Penetration

G4 Assessment

G5 Individualized Treatment Plan

G6 Individualized Treatment

G7 Training

G8 Supervision

G9 Process Monitoring

G10 Outcome Monitoring

G11 Quality Assurance (QA)

G12 Client Choice Regarding Service

Provision
TOTAL MEAN SCORE:

General Organizational Index (GOI)

(11-25-02)

	1	2	3	4	5
G1. Program Philosophy. The program is committed to a clearly articulated philosophy consistent with the specific evidence-based model, based on the following 5 sources: • Program leader • Senior staff (e.g., executive director, psychiatrist) • Practitioners providing the EBP • Clients and/or families receiving EBP • Written materials (e.g., brochures)	No more than 1 of the 5 sources shows clear understanding of the program philosophy OR All sources have numerous major areas of discrepancy	2 of the 5 sources show clear understanding of the program philosophy OR All sources have several major areas of discrepancy	3 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one major area of discrepancy	4 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one or two minor areas of discrepancy	All 5 sources display a clear understanding and commitment to the program philosophy for the specific EBP
***G2. Eligibility/Client Identification.** All clients with severe mental illness in the community support program, crisis clients, and institutionalized clients are screened to determine whether they qualify for the EBP using standardized tools or admission criteria consistent with the EBP. Also, the agency tracks the number of eligible clients in a systematic fashion.	≤20% of clients receive standardized screening and/or agency DOES NOT systematically track eligibility	21%-40% of clients receive standardized screening and agency systematically tracks eligibility	41%-60% of clients receive standardized screening and agency systematically tracks eligibility	61%-80% of clients receive standardized screening and agency systematically tracks eligibilit	>80% of clients receive standardized screening and agency systematically tracks eligibility
***G3. Penetration.** The maximum number of eligible clients are served by the EBP, as defined by the ratio: **# clients receiving EBP** **# clients eligible for EBP**	Ratio ≤ .20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio > .80

***These two items coded based on all clients with SMI at the site or sites where the EBP is being implemented; all other items refer specifically to those receiving the EBP.**

Total # clients in target population
_____ **Total # clients eligible for EBP % eligible: ___%**
_____ **Total # clients receiving EBP Penetration rate: ____**

General Organizational Index (GOI)

	1	2	3	4	5
G4. Assessment. Full standardized assessment of all clients who receive EBP services. Assessment includes history and treatment of medical/psychiatric/ substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors	Assessments are completely absent or completely nonstandardized	Pervasive deficiencies in two of the following: Standardization, Quality of assessments, Timeliness, Comprehensiveness	Pervasive deficiencies in one of the following: Standardization, Quality of assessments, Timeliness, Comprehensiveness	61%-80% of clients receive standardized, high quality assessments at least annually OR Information is deficient for one or two assessment domains	>80% of clients receive standardized, high quality assessments, the information is comprehensive across all assessment domains, and updated at least annually
G5. Individualized Treatment Plan. For all EBP clients, there is an explicit, individualized treatment plan *related to the EBP* that is consistent with assessment and updated every 3 months.	≤20% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 mos.	21%-40% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 mos.	41%-60% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 mos. OR Individualized treatment plan is updated every 6 mos. for all clients	61%-80% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 mos.	>80% of clients served by EBP have an explicit individualized treatment plan *related to the EBP*, updated every 3 mos.
G6. Individualized Treatment. All EBP clients receive individualized treatment meeting the goals of the EBP.	≤20% of clients served by EBP receive individualized services meeting the goals of the EBP	21%-40% of clients served by EBP receive individualized services meeting the goals of the EBP	41%-60% of clients served by EBP receive individualized services meeting the goals of the EBP	61% - 80% of clients served by EBP receive individualized services meeting the goals of the EBP	>80% of clients served by EBP receive individualized services meeting the goals of the EBP

General Organizational Index (GOI)

	1	2	3	4	5
G7. Training. All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) *within 2 months of hiring.* Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).	≤20% of practitioners receive standardized training annually	21%-40% of practitioners receive standardized training annually	41%-60% of practitioners receive standardized training annually	61%-80% of practitioners receive standardized training annuall	>80% of practitioners receive standardized training annually
G8. Supervision. EBP practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in the particular EBP. The supervision should be client-centered and explicitly address the EBP model and its application *to specific client situations.*	≤20% of practitioners receive supervision	21% - 40% of practitioners receive weekly structured client centered supervision OR All EBP practitioners receive supervision on an informal basis	41%-60% of practitioners receive weekly structured client centered supervision OR All EBP practitioners receive supervision monthly	61%-80% of EBP practitioners receive weekly structured client centered supervision OR All EBP practitioners receive supervision twice a month	>80% of EBP practitioners receive structured weekly supervision, focusing on specific clients, in sessions *that explicitly address the EBP model and its application*
G9. Process Monitoring. Supervisors and program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators.	No attempt at monitoring process is made	Informal process monitoring is used at least annually	Process monitoring is deficient on 2 of these 3 criteria: (1) Comprehensive & standardized; (2) Completed every 6 mos.; (3) Used to guide program improvements OR Standardized monitoring done annually only	Process monitoring is deficient on one of these three criteria: (1) Comprehensive and standardized; (2) Completed every 6 months; (3) Used to guide program improvements	Standardized comprehensive process monitoring occurs at least every 6 mos. and is used to guide program improvements

General Organizational Index (GOI)

	1	2	3	4	5
G10. Outcome Monitoring. Supervisors/program leaders monitor the outcomes for EBP clients every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome *related to the EBP*, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.	No outcome monitoring occurs	Outcome monitoring occurs at least once a year, but results are not shared with practitioners	Standardized outcome monitoring occurs at least once a year and results are shared with practitioners	Standardized outcome monitoring occurs at least twice a year and results are shared with practitioners	Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners
G11. Quality Assurance (QA). The agency has a QA Committee or implementation steering committee with an explicit plan to review the EBP, or components of the program, every 6 months.	No review or no committee	QA committee has been formed, but no reviews have been completed	Explicit QA review occurs less than annually OR QA review is superficial	Explicit QA review occurs annually	Explicit review every 6 months by a QA group *or steering committee for the EBP*
G12. Client Choice Regarding Service Provision. All clients receiving EBP services are offered choices; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services.	Client-centered services are absent (or all EBP decisions are made by staff)	Few sources agree that type and frequency of EBP services reflect client choice	Half sources agree that type and frequency of EBP services reflect client choice	Most sources agree that type and frequency of EBP services reflect client choice OR Agency fully embraces client choice with one exception	All sources agree that type and frequency of EBP services reflect client choice

Program _____ **Respondent #** _____ **Role** ____ **Interviewer** _____ **Date** _____ .

APPENDIX ZO

CRITERION		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
HUMAN RESOURCES: STRUCTURE & COMPOSITION						
H1	SMALL CASELOAD: client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	11 - 20	10 clients/clinician or fewer
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 36%.	37 - 63%.	64 - 89%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.
H3	PROGRAM MEETING: Program meets frequently to plan and review services for each client.	Program service-planning for each client 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.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup.	Supervisor provides services routinely as backup, OR Supervisor typically provides from 1 to 4.9 hours of direct service.	Supervisor typically provides from 5 to 9.9 hours weekly.	Supervisor provides direct services at least 10 hours or more weekly
H5	CONTINUITY OF STAFFING: program maintains 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: Program operates at full staffing.	Program has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	80-94%	Program has operated at 95% or more of full staffing in past 12 months.
H7	PSYCHIATRIST ON STAFF: there is at least one full-time psychiatrist per 100 clients assigned to work with the program.	Program for 100 clients has less than .10 FTE regular psychiatrist.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	.70-.99 FTE per 100 clients.	At least one full-time psychiatrist is assigned directly to a 100-client program.

Program _____ **Respondent #** _____ **Role** ____ **Interviewer** _____ **Date** _____ .

	CRITERION		RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)
H8	NURSE ON STAFF: there are at least two full-time nurses assigned to work with a 100-client program.		Program for 100 clients has less than .20 FTE regular nurse.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client program.
H9	SUBSTANCE ABUSE SPECIALIST ON STAFF: a 100-client program includes at least two staff members with 1 year of training or clinical experience in substance abuse treatment.		Program has less than .20 FTE S/A expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year S/A training or supervised S/A experience.
H10	VOCATIONAL SPECIALIST ON STAFF: the program includes at least two staff members with 1 year training/experience in vocational rehabilitation and support.		Program has less than .20 FTE vocational expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.
H11	PROGRAM SIZE: program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.		Program has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	7.5 - 9.9	Program has at least 10 FTE staff.

ORGANIZATIONAL BOUNDARIES

O1	EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.		Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined mission but the admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most referrals.	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	The program actively recruits a defined population and all cases comply with explicit admission criteria.
O2	INTAKE RATE: Program takes clients in at a low rate to maintain a stable service environment.		Highest monthly intake rate in the last 6 months = greater than 15 clients/month.	13 -15	10 - 12	7 - 9	Highest monthly intake rate in the last 6 months no greater than 6 clients/month.

Program _____ **Respondent #** _____ **Role** ____ **Interviewer** _____ **Date** _____ .

	CRITERION		RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)
O3	FULL RESPONSIBILITY FOR TREATMENT SERVICES: in addition to case management, program directly provides psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.		Program provides no more than case management services.	Program provides one of five additional services and refers externally for others.	Program provides two of five additional services and refers externally for others.	Program provides three or four of five additional services and refers externally for others.	Program provides all five of these services to clients.
O4	RESPONSIBILITY FOR CRISIS SERVICES: program has 24-hour responsibility for covering psychiatric crises.		Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program clients.	Program is available by telephone, predominantly in consulting role.	Program provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement.	Program provides 24-hour coverage.
O5	RESPONSIBILITY FOR HOSPITAL ADMISSIONS: program is involved in hospital admissions.		Program has involvement 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.
O6	RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: program is involved in planning for hospital discharges.		Program has involvement in fewer than 5% of hospital discharges.	5% - 34% of program client discharges are planned jointly with the program.	35 - 64% of program client discharges are planned jointly with the program.	65 - 94% of program client discharges are planned jointly with the program.	95% or more discharges are planned jointly with the program.
O7	TIME-UNLIMITED SERVICES (GRADUATION RATE): Program rarely closes cases but remains the point of contact for all clients as needed.		More than 90% of clients are expected to be discharged within 1 year.	From 38-90% of clients are expected to be discharged within 1 year.	From 18-37% of clients are expected to be discharged within 1 year.	From 5-17% of clients are expected to be discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.

NATURE OF SERVICES

S1	COMMUNITY-BASED SERVICES: program works to monitor status, develop community living skills in the community rather than the 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

Program _____ **Respondent #** _____ **Role** ____ **Interviewer** _____ **Date** _____ .

	CRITERION		RATINGS / ANCHORS				
			(1)	(2)	(3)	(4)	(5)
S2	NO DROPOUT POLICY: program retains a high percentage of its clients		Less than 50% of the caseload is retained over a 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: as part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., probation/parole, OP commitment) as indicated and as available.		Program passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients.	Program attempts outreach and uses legal mechanisms only as convenient.	Program usually has plan for engagement and uses most of the mechanisms that are available.	Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.
S4	INTENSITY OF SERVICE: high total amount of service time as needed.		Average of less than 15 min/week or less of face-to-face contact per client.	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 client.
S5	FREQUENCY OF CONTACT: high number of service contacts as needed.		Average of less than 1 face-to-face contact / week or fewer per client.	1 - 2 / week.	2 - 3 / week.	3 - 4 / week.	Average of 4 or more face-to-face contacts / week per client.
S6	WORK WITH INFORMAL SUPPORT SYSTEM: with or without client present, program provides support and skills for client's support network: family, landlords, employers.		Less than .5 contact per month per client with support system.	.5-1 contact per month per client with support system in the community.	1-2 contact per month per client with support system in the community.	2-3 contacts per months per client with support system in the community.	Four or more contacts per month per client with support system in the community.
S7	INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT: one or more members of the program provide direct treatment and substance abuse treatment for clients with substance use disorders.		No direct, individualized substance abuse treatment is provided by the team.	The team variably addresses SA concerns with clients; no formal, individualized SA treatment provided.	While the team integrates some substance abuse treatment into regular client contact, they provide no formal, individualized SA treatment.	Some formal individualized SA treatment is offered; clients with substance use disorders spend less than 24 minutes/week in such treatment.	Clients with substance use disorders spend, on average, 24 minutes / week or more in formal substance abuse treatment.

Program _____ **Respondent #** _____ **Role** ____ **Interviewer** _____ **Date** _____ .

CRITERION			RATINGS / ANCHORS				
			(1)	(2)	(3)	(4)	(5)
S8	DUAL DISORDER TREATMENT GROUPS: program uses group modalities as a treatment strategy for people with substance use disorders.		Fewer than 5% of the clients 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 clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.
S9	DUAL DISORDERS (DD) MODEL: program 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.		Program fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Program uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for persuasion of clients in denial or who don't fit AA.	Program uses mixed model: e.g., DD principles in treatment plans; refers clients to persuasion groups; uses hospitalization for rehab.; refers to AA, NA.	Program uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some s/a treatment.	Program fully based in DD treatment principles, with treatment provided by program staff.
S10	ROLE OF CONSUMERS ON TREATMENT TEAM: Consumers are involved as members of the team providing direct services.		Consumers have no involvement in service provision in relation to the program.	Consumer(s) fill consumer-specific service roles with respect to program (e.g., self-help).	Consumer(s) work part-time in case-management roles with reduced responsibilities.	Consumer(s) work full-time in case management roles with reduced responsibilities.	Consumer(s) are employed full-time as clinicians (e.g., case managers) with full professional status.

APPENDIX ZP

ACT Chart Peer Review Tool

Reviewer:	Date of Review:										
Assigned Clinician/Degree:	Date of 1st Contact:								Date Appt Offered:		
Review Month:	Funding Sources: (Program Name)										
Service/Chart Number:	*Select One*										
Please answer all questions - an incomplete peer review is not useful.	**Co-Occur-ring**		**MH**		**SA**		**High Risk**				

ASSESSMENT	**score 1=meets 0=does not meet**	**NA**	**ACT Specific**	**Comments**
Assessments are updated annually (outpatient only)				***Annual updates must be in record along with original assessment***
Assessments are updated when significant changes occur in the consumer's presentation. (same as #6)				***Assessment update must occur each time consumer presents with a significant change***
Consent for treatment includes the Consumer and/or Guardian signature, witness signature and is in a language understood by the Consumer. (MAD)				*The treatment record should contain a completely filled out consent form for treatment signed by the consumer and/or guardian. Score "0" if any data is missing.*
Presenting problems, along with relevant psychological and social conditions affecting the Consumer's medical and psychiatric status are documented.				*The assessment section of the clinical record includes the clinically significant psychosocial issues impacting the Consumer's presenting signs, symptoms, complaints and documented physical and mental illness*
Special status situations, such as imminent risk of harm (suicidal, homicidal or abuse), medically complex or elopement potential are prominently documented. (same as #8)				*The medical record must indicate and assess the current level of risk. NA applies if no special risk issue is documented*
A psychiatric evaluation has been completed, signed & dated. (same as #8)				*BiPolar seen within 14 days Y or N BiPolar labs in chart Y or N; Schiz seen within 14 days; Maj Dep seen within 30 days of diagnosis.*
A psycho-social assessment and history are documented including: psychiatric/treatment, medical, educational, legal, family, substance abuse, housing, and employment.				*The treatment record must contain a psycho-social assessment signed by the clinician.*
The Mental Status Evaluation (MSE) documents affect, speech, mood, thought, content, judgment, insight, attention or concentration, memory and impulse control. (MAD)				*The chart contains a completed MSE*
The Consumer's strengths are documented in the assessment. (DHI 24.6)				*The chart contains an admission and psychiatric assessment that documents the Consumer's strengths (e.g. family support, social support and housing)*

The Consumer's religious, spiritual and cultural values are documented in the assessment. (MAD)				*The treatment record must contain documentation of religious, spiritual and cultural values Consider single parenthood, dealing with a mental illness, lack of transportation/money/support system, etc.*
Consumer's 12 and older, there is a screening for past and present use of cigarettes, alcohol, illicit, prescribed and OTC drugs. (MAD)				*There is clear indication that drug use, nicotine, alcohol, etc. are documented or there is documentation that the Consumer does not use these substances.* *NA if consumer is under age 12.*
Diagnostic Review includes an SDMI diagnosis and is updated annually.				
LIVING ARRANGEMENTS	**score**	**NA**		**Comments**
The Consumer's living situation is clearly described in the treatment record. (MAD)				*Living situation is clearly documented in treatment record*
DSM-IV DIAGNOSES (ALL FIVE (5) AXES)	**score**	**NA**		**Comments**
DSM-IV diagnoses (Axis I-IV) are documented initially and updated at least annually.				*The treatment record must have all 5 axis completed every year.*
The DSM-IV diagnoses are consistent w/the presenting problems, target symptoms, history, mental status evaluation, and/or other assessment data. (MAD)				*There is documentation that the diagnoses match the presenting symptoms.*
MEDICATION MANAGEMENT	**score**	**NA**	NA if psychotropic meds not prescribed	**Comments**
Psychiatric notes reflect target symptoms, rationale for medications, treatment recommendations and response to medications.				*Abilify, Clozaril, Geodon, Haldol, Mellaril, Moban, Novane, Orap, Prolixin, Risperdal, Seroquel, Stelazine, Thorazine, Trilafon, Zydis, Zyprexa*
Written informed consent for medication (in a language understood by the consumer and/or guardian) is documented.				***AIMS required every 90 days*** *Initial _____Every 90 days_____ _____ _____ _____ _____ Discharge_____*
There is evidence that the consumer and/or guardian received information about the illness or target symptoms for which the medication was prescribed.				***Schizophrenia*** *dx receives AIMS every 90 days_____ _____ _____ _____*
There is evidence of discussion regarding the need to take the medication as prescribed and not stop w/o discussing it w/the physician.				*Based upon documentation, the reviewer can conclude the consumer was told how to take the medication and not to stop w/o doctor approval.*
The record indicates what medications have been prescribed, the dosages of each and the dates of initial prescriptions or refills. (MAD)				*Prescribed medications are documented. Dosages, routes and schedules for medications are documented.*
Allergies, or lack of known allergies and adverse reactions and sensitivities to pharmaceuticals and other substances are prominently noted. (MAD)				*There is documentation that the Consumer was asked about allergic reactions to medications and other substances.*
When medications are prescribed, there is evidence of an evaluation of the Consumer's response to the medication and adjustments are made as needed.				*There is documentation in the prescriber's notes of the consumer's response to the medication prescribed.*

When medications are prescribed that require serum level monitoring and/or other laboratory tests, those tests are done and the results are documented.				*There is documentation that appropriate labs were ordered and the results are in the treatment records. NA if the consumer is not on meds requiring monitoring and/or lab testing.*
RESPONSE TO TREATMENT/PROGRESS NOTES	**score**	**NA**		**Comments**
Progress notes reflect the response to treatment and the progress toward goals.				*There are progress notes reflecting consumer's response to treatment.*
Progress notes reflect documentation regarding the Consumer's status in treatment (missed and/or kept appointments).				*There is documentation in progress notes of missed and/or kept appointments.*
The record reflects continuity and coordination of care (i.e. consents for contact) w/health care institutions, consultants, ancillary and other non-behavioral health providers.				*There is documentation of signed releases when indicated. NA applies if consumer is not involved w/other services.*
The record reflects the active involvement of the family/primary caregivers in the assessment and treatment of the consumer, unless contraindicated.				*There is documentation of involvement of family or caregivers in the treatment process. NA if consumer is an adult w/o caretaker or the evaluation determined the involvement of family would be detrimental to recovery.*
The record documents preventive/recovery services as appropriate (e.g. relapse prevention, stress management, peer directed programs, wellness programs, lifestyle changes and referrals to community resources.				*There is documentation of recovery/prevention services as needed.*
The record reflects continuity and coordination of care w/ PCP.				*There is documentation of communication w/the PCP unless the consumer does have a PCP. NA applies if documentation states the consumer does not have a PCP.*
Progress note content supports the objective(s) identified from the tx plan that are addressed during that appointment.				
Program Director countersigns all Crisis related notes.				
Progress note identifies place of service				
Progress note justifies a billable service.				
ACCESS TO CARE	**score**	**NA**		**Comments**
For Inpatient: Follow-up appointments are offered within 7 or 30 days of discharge. (MAD)				***Pt readmitted to IP within 30 days Y or N*** *. NA applies if treatment record does not indicate consumer was an inpatient.*
Outpatient: Appointments are offered within 14 business days of initial contact for Medicaid funding and 10 business days for DOH funding.				*Routine=14 or 10 days Urgent=24 HRS Emergent = 30min/phone 8hr/Face*
The record reflects provider follow-up activities related to consumers who miss or reschedule appointments. (MAD)				*There is documentation that appointments were missed and that follow-up was done as a result.*
DISCHARGE	**score**	**NA**		**Comments**
The intake assessment and/or initial treatment plan indicate discharge planning was initiated upon admission.				*Preliminary discharge plans should be noted in the initial intake assessment.*

The discharge summary describes the presenting problem, course of treatment, treatment gains made, and specific (who, what and where) aftercare plans. (Same as #41)				*The record has a comprehensive discharge summary. NA applies if consumer is still in care.*
SUBSTANCE ABUSE	**score**	**NA**		**Comments**
The treatment record documents an Addiction Severity Index (ASI).				*SA DX, ASI required: Admission_____, 90 day F/U_____, every 120 days_____, Discharge_____*
The treatment record documents a substance abuse assessment/screen (e.g. SASSI, MAST, MIDAS) (MAD)				*The record has a substance abuse assessment /screen*
The record documents a substance abuse DSM IV diagnosis. (MAD)				*Substance abuse diagnosis is documented. NA applies if there is no substance diagnosis.*
The treatment record documents provision of SA tx by ACT or coordination of care including external referral to a substance abuse provider. (MAD)				*There is documentation of coordination of care. NA applies if no coordination of care is needed.*
Treatment strategies include group modalities.				
TREATMENT PLAN & RECOMMENDATIONS	**score**	**NA**		**Comments**
A treatment plan is present in the clinicial record.				*There is documentation that the treatment plan is relevant to primary diagnosis and Consumer agreed with goals.*
A master/comprehensive treatment plan was completed within 30 days or the third session of outpatient services.				*There is documentation of a completed master treatment plan signed and dated, within 30 days or the third session form the initial intake date.*
A treatment plan review was completed at least every 90 days for Outpatient Services				*Documentation of a completed treatment plan review at least every 90 days for adults & 30 days for children, signed and dated.*
Treatment plans are consistent with diagnoses and Consumer's agreed upon goals. (MAD)				*There is documentaiton that the treatment plan revelant to primary diagnosis and Consumer agreed with goals.*
Goals/Objectives are measurable				*There is documentation of measurable goals and objectives.*
Goals/Objectives are **individualized.** (MAD)				*There is documentation the goals and objectives are based on the individual's assessment/needs.*
There is a time frame for goal attainment/problem resolution. (Same as #54)				*There is documentation of time frames.*
Treatment interventions are consistent w/the treatment plan.				*There is documentation of treatment modalities and interventions related to the goals of treatment.*
The treatment plan is written in a language the consumer can understand. (MAD)				*There is documentation that the consumer participated in the treatment plan development and has understanding of the plan, with a consumer signature.*
Documentation includes the signature of appropriate parties.				*The treatment plan is signed by th treatment team.*

Treatment plan reflects utilization of Consumer's strengths. (MAD)					*Consumer strengths are incorporated in treatment plan.*
	TOTAL				

Documents that require signatures and an update review at least once a year. The only exception is the DOH form, which is completed once. ***Check all that apply***

[ ]	Clients Rights, Responsibilities, Grievance	[ ]	DOH Release (1 time requirement)
[ ]	Consent For Treatment	[ ]	Division of Vocational Rehabilitation (DVR)
[ ]	Medication Informed Consent	[ ]	School Release
[ ]	HIPAA Privacy Notice	[ ]	PO Release
[ ]	HIPAA Privacy Notice/ Substance Abuse C.F.R.	[ ]	SSI Release Form
[ ]	EPSDT Health Questionaire	[ ]	Form
[ ]	PCP Notification		
[ ]	PCP Release		

ACT SERVICE AUDIT TOOL
AUDIT PERIOD:_____

HSD REVIEWER:_____**REVIEW DATE:**_____

CLIENT NAME:_____**MEDICAID NUMBER:**_____

DOB:_____**AGE:**_____

Check the appropriate box and note comments in spaces provided.

	Yes	**No**
1. Does the client meet the eligibility requirements for participation in the ACT program?		
-Client is 18 years or older		
-A severe mental illness has been diagnosed (Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Psychotic Depression) by a licensed professional		
-Client has severe problems completing ADLs		
-Significant history of involvement in behavioral health services		
-Repeated hospitalizations and/or incarcerations		
-Frequent use of emergency services		
2. A comprehensive assessment, establishing medical necessity was completed within 40 days of client admission to ACT Program		
3. The file contains a culturally relevant service plan that is responsive to the individual's choices		
4. The individual's service plan was signed by a psychiatrist, ACT team leader and the client prior to the initiation of services		
5. Does the individual service plan contain the following elements:		
-A diagnosis of severe disabling mental illness (Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Psychotic Depression) by a licensed professional		
-Plans to address psychiatric conditions		
-Treatment goals & objectives (including target dates)		
-Preferred treatment approaches and related services		
-Educational, vocational, social, wellness management, residential or recreational goals, and concrete and measurable objectives		
-Psychopharmacological treatment plan		
-Crisis/relapse prevention plan including advance directive		
-An integrated substance abuse and mental health service plan for individuals with co-		

occurring disorders		
6. The individual service plan is reviewed and updated every six months	**Yes**	**No**
7. Do the progress notes reflect service interventions identified in the individual service plan as related to the following act services:		
Psychiatric Services		
Medication Management		
Counseling Services		
Psychotherapy		
Substance Abuse Treatment		
Housing Support		
Employment/Vocational Services		
Rehabilitation Services		
Case Management Services		
8. Do the progress notes and/or other relevant documentation reflect the billed modifier, level of interaction with the client and the service provider? Modifier activities must be indicated in the service plan. (*See below for modifiers)		
9. Do the progress notes and/or other relevant documentation reflect the number of units billed to Medicaid?		

***Modifier Activities:**

U1 = Face-to-face encounter with a client; encounters can occur outside the office (cell phone contacts and family or collateral contact cannot be billed as face-to-face encounters).

U2 = Collateral encounter occurred with members of the client's family or household, or with other contacts who interact with the client regularly and who are indentified in the service plan as having a role in the client's treatment.

U3 = Assertive outreach involving the ACT Team member monitoring the client's relationships within the community and early intervention if difficulty arises. The team must closely monitor relationships that the client has within the community.

APPENDIX ZQQ

Tool for Measurement of Assertive Community Treatment (TMACT)©

PROTOCOL

Part II: Itemized Data Collection Forms

Version 1.0
Revision 3

February 16, 2018

Recommended Citation:
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Contact Information for the TMACT:

For more information regarding the TMACT, including training and consultation options in administering this fidelity tool, please contact one of the following TMACT authors:

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Please refer to *TMACT Protocol Part I: Introduction* for an overview of the fidelity review process, as well as guidelines and restrictions as it relates to training in the TMACT.

TMACT Fidelity Review

Program Information Cover Sheet

Date: _____ **Fidelity Evaluator(s):** _____

Program and Team Name: _____

Address: _____

Catchment Area: _____

Contact Person: _____

Telephone: _____

Email: _____

# of staff (all): _____

# of clients at time of review: _____

# of clients one year ago: _____

Maximum capacity of clients: _____

Date of team start-up: _____

Funding source: _____

Approximate monthly funding per client: _____

Data Sources Used:

- ☐ Chart Review
- ☐ Daily Team Meeting Observation
- ☐ Treatment Planning Observation
- ☐ Home/Community Visits (#: __)
- ☐ Team Leader Interview
- ☐ COD Specialist Interview (#:__)
- ☐ Employment Specialist Interview (#:__)
- ☐ Peer Specialist Interview (#:__)
- ☐ Nurse Interview (#:__)
- ☐ Psychiatric Care Provider Interview (#:__)
- ☐ Mental Health Therapist Interview (#:__)
- ☐ Client Interview(s) (#:__)
- ☐ Family Member Interview (# interviewed)
- ☐ Other (specify): _____
- ☐ Other (specify): _____
- ☐ Other (specify): _____

TMACT ITEMIZED DATA COLLECTION FORMS

Table of Contents

Additional Data Collection Forms

TMACT Fidelity Review

Interview Checklist

Team Leader Interview (*Optional phone interview items to be asked before on-site fidelity review)

- ☐ Program Info P. iii*
- ☐ Intro P. 1
- ☐ OS1 P. 3*
- ☐ OS3 P. 7-8
- ☐ OS4 P. 9-10
- ☐ PP2 P. 176
- ☐ PP1 P. 173
- ☐ CP4 P. 113
- ☐ OS5 P. 15*
- ☐ OS6 P. 17-18
- ☐ OS7 P. 20
- ☐ OS8 P. 23*
- ☐ OS9 P. 24-25
- ☐ OS10 P. 29*
- ☐ OS11 P. 31*
- ☐ OS12 P. 33-34
- ☐ CT1 P. 36*
- ☐ CT2 P. 38-39
- ☐ CT3 P. 42-43*
- ☐ CT5 P. 52
- ☐ CT7 P. 58
- ☐ CP2 P. 105-107
- ☐ PP4 P. 184-186
- ☐ ST2 P. 69
- ☐ EP4 P. 147-148
- ☐ ST5 P. 84
- ☐ EP5 P. 154
- ☐ ST8 P. 98*
- ☐ CP5 P. 115*
- ☐ EP6 P. 158-159
- ☐ EP7 P. 162
- ☐ EP8 P. 167-169**
- ☐ CP6 P. 116*

Nurse Interview

- ☐ CT6 P. 56
- ☐ CT7 P. 59-61
- ☐ CP7 P. 122
- ☐ CT4 P. 47

Psychiatric Care Provider Interview

- ☐ Intro P. 2
- ☐ CT3 P. 43
- ☐ CT4 P. 45-47
- ☐ EP4 P. 148-149
- ☐ OS6 P. 18
- ☐ CT5 P. 53-54
- ☐ CT7 P. 59

Clinician Interview

- ☐ Intro P. 1
- ☐ OS6 P. 18
- ☐ OS9 P. 25-26
- ☐ CT2 P. 39
- ☐ CT4 P. 48
- ☐ CT5 P. 54-55
- ☐ CT7 P. 61
- ☐ EP4 P. 150-151
- ☐ EP5 P. 154-156
- ☐ EP3 P. 144
- ☐ ST3 P. 78
- ☐ ST6 P. 92
- ☐ ST8 P. 101
- ☐ EP7 P. 163
- ☐ CP8 P. 126-127
- ☐ EP6 P. 159-160
- ☐ CP2 P. 107-108
- ☐ PP2 P. 177
- ☐ PP1 P. 174

COD Specialist Interview

- ☐ ST1 P. 64
- ☐ ST2 P. 70-73
- ☐ EP4 P. 149
- ☐ EP1 P. 136
- ☐ ST3 P. 77
- ☐ CT2 P. 40

Employment Specialist Interview

- ☐ ST4 P. 79-80
- ☐ ST5 P. 85-87
- ☐ EP2 P. 140
- ☐ EP5 P. 153
- ☐ ST6 P. 91
- ☐ CT2 P. 40

Peer Specialist Interview

- ☐ ST7 P. 93-94
- ☐ ST8 P. 99-100
- ☐ EP3 P. 144
- ☐ CT2 P. 40
- ☐ EP4 P. 149
- ☐ EP5 P. 154

Client Interview

- ☐ Intro P. 2
- ☐ CT4 P. 48
- ☐ ST5 P. 88
- ☐ ST8 P. 101
- ☐ CP6 P. 117
- ☐ EP6 P. 160
- ☐ EP8 P. 170
- ☐ PP2 P. 178
- ☐ PP4 P. 183-184

Housing Specialist Interview

- ☐ EP8 P. 167-169**

TMACT Fidelity Review

Other Data Source Checklist

Chart Review

- ☐ OS2 P. 5
- ☐ OS6 P. 17
- ☐ CT4 P. 45
- ☐ CT7 P. 58
- ☐ ST1 P. 64
- ☐ ST4 P. 79
- ☐ ST7 P. 93
- ☐ CP1 P. 104
- ☐ CP3 P. 112
- ☐ CP4 P. 113
- ☐ CP6 P. 116
- ☐ CP7 P. 119-129
- ☐ CP8 P. 119-129
- ☐ EP1 P. 130-146
- ☐ EP2 P. 130-146
- ☐ EP3 P. 130-146
- ☐ EP7 P. 162
- ☐ EP8 P. 170
- ☐ PP1 P. 173
- ☐ PP2 P. 176
- ☐ PP3 P. 181

Weekly Client Schedules

- ☐ OS4 P. 11
- ☐ PP3 P. 181

Daily Team Meeting

- ☐ OS2 P. 5
- ☐ OS3 P. 7
- ☐ OS4 P. 9
- ☐ ST3 P. 77
- ☐ ST6 P. 91
- ☐ ST8 P. 98
- ☐ CP2 P. 108
- ☐ EP6 P. 158
- ☐ EP7 P. 164
- ☐ EP8 P. 170
- ☐ PP3 P. 181
- ☐ PP4 P. 184

Team Survey

- ☐ OS1 P. 3
- ☐ OS3 P. 7
- ☐ OS5 P. 15
- ☐ OS6 P. 17
- ☐ OS7 P. 20
- ☐ OS8 P. 23
- ☐ OS9 P. 24
- ☐ OS10 P. 29
- ☐ OS11 P. 31
- ☐ OS12 P. 33
- ☐ CT1 P. 36
- ☐ CT2 P. 38
- ☐ CT3 P. 42
- ☐ CT6 P. 56
- ☐ ST1 P. 64
- ☐ ST2 P. 69
- ☐ ST4 P. 79
- ☐ ST7 P. 93
- ☐ ST8 P. 98

Excel spreadsheet

- ☐ OS8 P. 23
- ☐ CT4 P. 45
- ☐ CT7 P. 58
- ☐ ST1 P. 64
- ☐ ST2 P. 69
- ☐ ST4 P. 79
- ☐ ST5 P. 84
- ☐ ST7 P. 93
- ☐ ST8 P. 98
- ☐ CP2 P. 105
- ☐ CP5 P. 115
- ☐ CP7 P. 119-129
- ☐ CP8 P. 119-129
- ☐ EP1 P. 130-146
- ☐ EP2 P. 130-146
- ☐ EP3 P. 130-146
- ☐ EP5 P. 153
- ☐ EP6 P. 158
- ☐ EP7 P. 156
- ☐ EP8 P. 170
- ☐ PP4 P. 186

Treatment Planning Meeting

- ☐ PP2 P. 176

Other Agency Docs/Tools

- ☐ OS4 P. 11
- ☐ CT2 P. 38

Direct Observation

- ☐ OS12 P. 34
- ☐ PP4 P. 184

Community Visits

- ☐ PP4 P. 194

Introduction Interview Questions:	
DATA SOURCES	
Team Leader	
Before we begin, let's make sure we have a copy of the forms we requested for this fidelity review, as we may be referring to them during our visit. [Introductory Statement] ***We also want to make sure the purpose of this fidelity evaluation is clear to you:*** [insert purpose here.] ***The specific information you provide to us will not be shared in a way that's tied back to you. An exception is us sharing feedback that is particularly positive. Also, our goal is to give you the most accurate feedback to help your team. The more factual the information we receive, the better we are at making targeted recommendations. Do you have any questions?*** [If this is a new team or team leader:] ***We'd like to start by asking what do <u>you</u> think the purpose and philosophy behind Assertive Community Treatment (or ACT) is or should be?*** [If this is a follow-up fidelity review with this team:] ***Tell us about some of the changes your team has made since the last review.***	☐ *admission criteria and screening tools;* ☐ *assessments;* ☐ *treatment plans;* ☐ *crisis plans;* ☐ *transition readiness (i.e., graduation) assessment or a list of transition readiness criteria;* ☐ *a recently completed daily team schedule;* ☐ *an example of a team member individual schedule;* ☐ *a de-identified (i.e., cross-out name[s]) copy of a client log page;* ☐ *a de-identified copy of a weekly/monthly client schedule;* ☐ *any health communication forms used to correspond with non-ACT providers; and* ☐ *any relevant agency or program policy guiding your work.* *A copy of a Client ID key with client names listed to reference during interviews.*
Clinicians	
[If helpful, provide the same introductory statements about confidentiality as noted above.] ***We'd like to start by asking what do <u>you</u> think the purpose and philosophy behind Assertive Community Treatment (or ACT) is or should be?*** [If this is a follow-up fidelity review with this team:] ***Tell us about some of the changes your team has made since the last review.***	

Psychiatric Care Provider	
[If helpful, provide the same introductory statement about confidentiality as noted above.] [If this is a new team or psychiatric care provider:] ***We'd like to start by asking what do <u>you</u> think the purpose and philosophy behind Assertive Community Treatment (or ACT) is or should be?*** [If this is a follow-up fidelity review with this team:] ***Tell us about some of the changes your team has made since the last review.***	
Clients	
Thank you for meeting with us today. We're visiting this ACT team to better understand what they're doing well and what they could be doing better. We're interested in your experience with this ACT team. Your individual responses will be kept confidential. Do you have any questions? [If the agency or situation requires it, review the agency's provided confidentiality/consent form and ask them to sign. The strong preference is for this interview to be completed without ACT team members present.] ***Generally, what do you think about the ACT team?*** ***How have they helped you?*** ***Can you share any concerns you have about the ACT team?*** ***What would you like them to do differently, if anything at all?***	

OS1. Low Ratio of Clients to Staff

Definition: The team maintains a low client-to-staff ratio, not to exceed 10:1, which includes all direct service staff except for the psychiatric care provider. The staff count does NOT include other administrative staff such as the program assistant or other managers assigned to provide administrative oversight to the team.

Rationale: ACT teams are intended to serve a high service-need clinical population and to be the primary service provider across a range of service domains. Therefore, ACT teams should maintain a low client-to-staff ratio to ensure adequate intensity and individualization of services.

DATA SOURCES (* denotes primary data source)

Team Survey*

See item #1 regarding staff FTE _____ and item #7a regarding number of clients currently enrolled_____.

Team Leader Interview*

Briefly review and confirm whether each staff/team member meets inclusion criteria below, and identify which staff were employed with the team in past three months, but are no longer (this information will be helpful when conducting the chart review). Ensure that all current staff are clearly listed in the Team Survey.	

ITEM RESPONSE CODING

Inclusion Criteria

ACT Staff:

- Count all part- and full-time staff that provide direct services (e.g., COD specialist, employment specialist, team leader) who work exclusively with the ACT team at least 16 hours a week (16/40 = 0.40 FTE) and attend the daily team meeting at least twice a week.
- Count only staff who have started work with the team at the time of the on-site review (i.e., do not count staff who have merely received, or accepted, a job offer).
- Count interns if they meet above criteria and will work with the team for at least six months.
- In the event a team member is on extended leave and the team has filled this position with interim staff, only count the permanent staff person on extended leave (i.e., do not credit both the permanent and temporary staff member for this one position).

Clients:

- Include all clients enrolled on the team, even very recent admissions. Do not exclude clients currently enrolled on the team who are difficult to engage and have not had recent contact with the team.

Exclusion Criteria

Do not count the following staff in this rating:

- Psychiatric care provider (i.e., psychiatrist, nurse practitioner, or physician assistant serving in the role of the psychiatric care provider).
- Administrative support staff, such as the program assistant, or other managers assigned to provide administrative and/or clinical oversight to the team.
- Staff who are employed by the team, but who have been on extended leave for three months or more.

Note: Evaluate whether staff FTE reflects actual hours worked vs. time available to the team (i.e., count hours worked, not mere availability)

Formula:	
# of clients currently enrolled --- # FTE staff	Note: 1.0 FTE equals the hours worked by one team member on a full-time (i.e., 40 hours a week) basis. To calculate the FTEs across all team members, you may need to first convert number of hours worked to FTEs (e.g., 32 hours a week is 0.8 FTE. Formula: 32/40 = 0.8), then add all team member FTEs together.

OS1 Low Ratio of Clients to Staff	**1**	**2**	**3**	**4**	**5**
	26 clients per team member or more.	19 – 25	14 – 18	11 – 13	10 clients per team member or fewer.

OS2. Team Approach

Definition: ACT staff work as a transdisciplinary team rather than as independent team members; ACT staff know and work with all clients rather than carry individual caseloads. Although the entire team shares responsibility for each client, each team member contributes expertise as determined by client goals and needs identified in the person-centered plan, and carried out by each individual treatment team (ITT).

Rationale: The team approach ensures continuity of care for clients, and creates a supportive organizational environment for team members. Furthermore, given that each client has personal goals and a broad range of service needs, deliberate scheduling of service interventions delivered by those team members with the most expertise and skill in those areas suggests the need for such a team approach to service delivery.

DATA SOURCES (* denotes primary data source)

Chart Review* - Chart Review Log Part I (p. 195-196) and Chart Review Tally Sheet Part I (p.197-198)

Review randomly selected charts (at least 20% sample or a minimum of 10 charts in smaller teams). Use the most recent and complete 4-week period from the chart (within 3 months of the site visit dates), and attempt to avoid time frames that do not represent typical team service provision (e.g., during a recent holiday or multiple staff training days).

Count the number of direct service ACT team members, including the psychiatric care provider, who have had a face-to-face contact with the client during this time; exclude any staff predetermined to not meet inclusion criteria specified in item OS1 and OS5. Include team members who are no longer employed by the team at the time of the on-site visit, but were employed during the chart period.

Note: If the team can provide reliable and valid data from their electronic medical record for all individuals served by the team, these data can be used to rate this item, using the same four-week calendar period. Refer to TMACT Part I for further instructions.

Daily Team Meeting - Observation Form (p. 189-192)

Observe how staff members are scheduled to provide services to clients. Ideally, staff assignments will vary naturally based on each client's treatment plan and careful matching of individual client needs with staff expertise and established rapport; however, the team should also try to diversify staff scheduling to foster ongoing relationships between each client and several team members. Note how the use of geographical location break-outs or grids inform staff scheduling patterns.

ITEM RESPONSE CODING

Rating Guidelines

Use the chart review as the primary data source, unless the team can provide full caseload data that has been judged to be reliable and valid. The evaluator may judge whether select contacts should be included given the quality of contacts (e.g., a team leader documents a contact that appears to be an unplanned run-in at the agency, with no apparent purpose). If the information from various sources is inconsistent (e.g., daily team meetings seem to point to a higher rate of shared caseloads than do the records), ask the team leader to help you understand the discrepancy.

Refer to observations within the daily team meeting regarding the quality of a team approach (e.g., thoughtful assignment of staff according to treatment plans and individual treatment teams (ITTs), which is recommended, or random assignment of staff, which is not recommended). Overall low frequency of contacts could decrease the opportunity for a true team approach, as well. Such information can guide quality improvement feedback.

For the final tally, calculate the percent of client charts where at least 3 team members met with the client in the 4-week period, but exclude charts with no documented face-to-face contacts in that period. As an example, 15 charts are reviewed, with 2 charts having no face-to-face contacts. Ten (10) charts were observed to have face-to-face contacts with at least 3 team members. The final rating is then 10/13 = 77%.

Formula:

$$\frac{\text{\# of clients with face-to-face contacts with at least 3 team members in a 4-week period}}{\text{Total \# of charts reviewed (include only those with at least 1 face-to-face contact)}} \textbf{ (X 100)}$$

Refer to the TMACT Calculation Workbook or to the Chart Review Tally Sheet to enter and compute these data.

	1	2	3	4	5
OS2 Team Approach	Fewer than 25% of clients have face-to-face contacts with at least 3 team members in 4 weeks.	25 – 52%	53 - 74%	75 - 89%	90% or more clients have face-to-face contact with at least 3 team members in 4 weeks.

OS3. Daily Team Meeting (Frequency & Attendance)

Definition: The team meets daily to review and plan services. To this end, most team members should be present to effectively carry out such a review. To constitute a daily team meeting, it must meet the following criteria: there is a review of each client's status; there is planning for future services; most team members are present.

Rationale: Daily team meetings allow ACT staff to briefly discuss clients' status over the past 24 hours (or weekend), problem-solve approaches to address current or prevent future crises, and discuss planned treatment and rehabilitation contacts, ensuring that all clients receive the best possible services. Regular, consistent, in-person attendance by all staff ensures optimal information-sharing and continuity, and promotes team cohesion.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to Table 1 (Item #1) where the number of daily team meetings attended by staff per week should be listed.

Daily Team Meeting - Observation Form (p. 189-192)

Note who attends the meeting, for how long, and whether conversations indicate that the team has met in previous days to share their assessment and service delivery information. Inquire during staff interviews of possible discrepancies between what was reported in the Team Survey and what was observed (e.g., a major life event for a client was commented on, and a team member reacts as if hearing this for the first time even though this life event occurred two weeks ago). Follow-up inquiry would explore reasons for this discrepancy, such as the team member may just be returning from vacation, this team member's typical attendance may be lower than reported, the team is not meeting daily as reported, and/or the quality of information shared during a typical meeting may be inadequate.

Team Leader Interview

How often does the ACT team meet as a full group to review and plan daily services? ***Do scheduled daily team meeting times vary throughout the week?*** [If yes, inquire reasons for variation and how meetings may change in focus and attendance across the week.] ***What are the expectations for staff attendance? How do you maximize staff attendance?*** [Prompt for team's use of multiple service shifts and/or staggered staffing across the week (e.g., using 4x10-hour shifts) and how that may affect attendance in the daily meeting.] ***How is information shared or passed on to staff members who are <u>not</u> in attendance? In what way is telecommunication used?*** [Refer to the Team Survey and inquire about days that appear to have fewer team members present.]	

How does the attendance we observed at the daily team meeting compare with typical attendance?	

ITEM RESPONSE CODING
Inclusion Criteria
Frequency credit considerations: To count as a daily team meeting, most team members need to be present and scheduled meeting times facilitate meaningful review of client status over the past 24 hours (e.g., the meeting is consistently scheduled at approximately the same time each day). If a team meets in the morning on Monday and Tuesday, the afternoon on Wednesday, and then meets again in the morning on Thursday and Friday, do not count the Thursday meeting as one of the daily team meetings. **Full attendance credit considerations:** o **Attendance:** Attendance in person is expected. Team members calling or video-conferencing into the meeting should be the exception, not the norm. In-person attendance offers better opportunities for meaningful exchanges, reduces multi-tasking that detract from attending to the meeting content, and provides the opportunity for the team to work together and enhance team operations. o **Psychiatric Care Provider:** A psychiatric care provider should be present to participate in the daily team meeting at least twice a week. The expectation is full attendance rather than only attending a portion of the meeting. o **Sufficient Communication**: There should be adequate processes in place to ensure communication of relevant information for those not in attendance. If there are routine absences due to two separate shifts or staff with 4x10-hour shift coverage, the team should ensure that most team members are in attendance. This may require changing the time of the daily team meeting or changing staff scheduling patterns to ensure more team member attendance. As described in OS1, if a person does not attend a daily team meeting at least twice a week, they are not to be considered as part of the team.
Exclusion Criteria
Do not include administrative or treatment planning meetings for this item. If a team reports holding daily team meetings five days a week, but it is later revealed that one such meeting is an administrative meeting and there is no basic review and planning of service contacts, rate based on four daily team meetings per week.
Rating Guidelines
The team leader interview is the primary data source. Corroborate with observation of the daily team meeting.

	1	2	3	4	5
OS3 Daily Team Meeting (Frequency & Attendance)	Team meets fewer than 2 days a week.	Team meets 2 days a week.	Team meets 3 days a week with or without full attendance OR team meets 4 days a week, but without full attendance.	Team meets 4 days a week with full attendance OR team meets 5 days a week, but without full attendance.	Team meets 5 days a week with full attendance.

OS4. Daily Team Meeting (Quality)

Definition: The team uses its daily team meeting to:
(1) Conduct a brief, but clinically-relevant review of all clients & contacts in the past 24 hours AND
(2) Record the status of all clients.

The team develops a daily staff schedule for the day's contacts based on:
(3) Weekly/monthly client schedules,
(4) Emerging needs,
(5) Need for proactive contacts to prevent future crises;
(6) Staff are held accountable for follow-through.

Rationale: Daily team meetings allow ACT staff to systematically update information, briefly discuss clients' status over the past 24 hours, problem-solve approaches to address current or prevent future crises, and discuss planned treatment and rehabilitation contacts, ensuring that all clients receive the best possible services.

DATA SOURCES (* denotes primary data source)

Daily Team Meeting* - Observation Form (p. 189-192)

Refer to Table 2 below for guidance on what to attend to during the daily team meeting.

Team Leader Interview*

(Note**:** Ask daily team meeting questions after observing a daily team meeting. With each question, reference specific observations on how the meeting was conducted.) ***Was the daily team meeting we observed today typical of your daily team meetings, and if not how was it different?*** ***How long is a typical daily team meeting?*** [Ask follow-up questions if there is a discrepancy between what was observed and what is typical] ***Can you summarize for us the roles of various team members in facilitating the daily team meeting?*** *Who was writing/ entering information into the daily client log? Who was leading the roll call of clients? Who, if anyone, was managing today's schedule? Did anyone have out yesterday's schedule for review?* ***What directions do team members receive on what to share during the roll call?*** [Further inquire about how lengthier conversations may be managed, the level of information-sharing that is expected, and whether team members are doing their own documentation into the log prior to the daily team meeting and how that may impact the report out during the meeting.]	

How do you determine what needs to happen with each client each day? ***Do you use Individual Treatment Teams (ITTs, and how do you create ITTs)?*** ***Is a staff schedule created daily?*** [If yes:] ***Using what information?*** [Prompt for the extent to which they use the weekly/monthly client schedules to develop their daily staff schedule and how the client schedule itself is created and updated. Pay attention to the extent to which geographic location grids are used to schedule contacts for the day, and whether additional practice standards (e.g., productivity) drive scheduling. Also listen for efforts to schedule out more specific interventions.] ***What is your approach to addressing clients' emerging needs identified during the daily team meeting*** *(e.g., crisis contacts or unplanned contacts based on new information shared during the daily team meeting)**?*** [Refer to specific examples observed during the daily team meeting.] ***When you have a client who isn't currently in crisis, but you see signs or have concerns that they may go into crisis soon, how is that handled during the daily team meeting?*** *Can you give me an example?* [Refer to specific examples observed during the daily team meeting.] ***Do you have any way of monitoring to ensure staff follow-up on scheduled contacts and interventions?*** [If yes:] *Can you describe to me what that is? How do you identify and address a client with a sequence of missed contacts or attempts?* [Reference specific observations from team meeting, if relevant; determine whether staff are accountable for contacts only, or delivery of assigned interventions.]	

Weekly/Monthly Client Schedules* and Chart Review (Treatment Plans)* - Chart Review Log Part II (p. 197-198)

Weekly/Monthly Client Schedules are created for each client, derived from the treatment plan, and regularly updated. These schedules display planned services (i.e., regular contacts and scheduled appointments) either weekly or monthly to meet objectives and goals listed in clients' treatment plans (See example in Table 1).

- Cross-reference client schedules with the treatment plans and services documented in the progress notes for the same clients whose charts are reviewed. Is there an appreciable tie between plans, schedules, and services to suggest that client schedules are optimally used to bridge plans and daily scheduling?
- Examine the level of detail regarding services specified in the client schedule.

Daily Staff Schedule*

Typical daily staff schedules (or "daily team schedule") include all the pre-planned staff contacts with each client for that day (as driven by each weekly/monthly client schedule), as well as newly scheduled contacts based on clients' emerging needs or the need to proactively engage clients to prevent future crises. Daily staff or team schedules may also include planned indirect time, such as clinical supervision and documentation.

If the team leader confirms that the team uses client schedules to develop daily staff (team) schedules, examine the following:

- Level of detail regarding services scheduled to be delivered that day and approximate time of delivery
- Scope of services provided (e.g., is a single client receiving a range of services?)
- Number of clients scheduled out to be seen by individual team members (e.g., if a single team member is scheduled to see eight people in one day, this suggests more limited contacts and less robust treatment interventions)
- The extent to which the schedule appears to follow from a treatment plan (ideally, via client schedules) and demonstrates responsiveness to emerging issues.

Ensuring Staff Accountability*

The intent of this function is not to micromanage staff activities, but to assure that clients are receiving the level and type of services that they need. **If the team leader confirms that they have a mechanism to ensure staff accountability, ask to see it.**

ITEM RESPONSE CODING

Rating Guidelines

Use Table 2 Guidelines to evaluate the extent to which the daily team meeting fully serves all six functions.

Table 1. Sample Weekly Client Schedule

Name: Joe Smith	**ITT:** Jeff, Employment Specialist; Jan, Peer Specialist; Sandra, Care Coordinator

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday/Sunday
AM	9:30-11 Med management/education; Career Profile—Jeff, Emp Specialist		10:30 – 11:00 Psych and med evaluation—Dr. Klein (3rd week of every month only) 11:00 – 12pm WMR Group—Jan, Peer Specialist		9:30-10:30 Med management; activities of daily livings (ADL) assistance and skills training (house cleaning) - Sandra, care coordinator	
PM						2-4 Social skills training in community—Weekend Staff on Rotation (2nd and 4th Saturday)

Consumer Log: Joe Smith			
Feb, 2017	**Contact**	**Type**	**Staff**
1			
2M			
3	Meds. Eating ▲froz veg; scouted employers in neigh. Gd mood	F2F	JC
4			
5	Grocery; selected 2 fruits to try. Engaging /friendly. IMR	F2F	FA/JB
6			
7	Library; coached library card and check-out. Quiet	F2F	MM
8			
9M			
10	Not home	A	JC
11			
12	Reviewed cupboard nutrition; IM – quiet. IMR, but no partic	F2F	FA
13			
14	Library; soc skills – practiced introductions. Quiet. ?Par?	A	MM
15			
16M			
17	Meds. Refused to leave home. More guarded.	F2F	JC
18	Check-in –conversational, slightly guarded	F2F	MM
19	Not answering door/phone	A	FA
20			
21	Park; did not want to practice soc exchanges. ▲Paranoia	F2F	MM
22	Call to Joe – reported feeling ok, mildly conversational and open	Ph	MM
23M			
24	Meds. Increased suspiciousness. No meds ~3 days. Took dose	F2F	Dr. X
25	Assessment; refused voc walk. Reported taking meds	F2F	JC
26	Assment – not eating much. ?meds. Called sister	F2F/P	FA
27	Sister –crisis call – facilitated vol hosp.	PH	
28	Hospital visit. Spoke with SW and Joe -- guarded	F2F	JB

Table 2. Daily Team Meeting (Quality)			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Conduct a brief, but clinically-relevant review of all clients and contacts in the past 24 hours.	• Team does not review all clients (this includes when the report is organized by each staff member taking turns reporting out on who they saw, skipping over those not seen, whether scheduled to be seen or not); or • Only one or two team members simply read through the previous day's recorded contacts for all clients (rather than each team member reporting on their own contacts to the team, which is then recorded).	The team reviews all clients, but the content of the report is either: • Too brief to give enough information to the team about status and possible next steps; or • Too lengthy to provide enough time to review all clients in an efficient manner (i.e., excessive time is spent on several clients, which results in rushed reports on other clients); or • Too extensive in that they repeatedly review clients who were seen more than 24 hours prior to the meeting. Partial credit may be warranted if the meeting was unfocused and/or generally poorly attended to by staff (e.g., many side conversations ensued).	If the client was scheduled and seen the previous day/weekend, team member describes mental status, relevant behaviors, & staff interaction with client. If client was scheduled and not seen, team may note barriers to contact (e.g., timing of day) or concerns about missed appointment. If the client was not scheduled, no report is typically given. Ideally, this meeting is focused, but also incorporates some dynamic staff interaction that facilitates ongoing clinical assessment and planning. A small team serving 50 should be able to complete their daily meeting within 45 minutes to an hour; a larger team serving 100 should be able to complete it within an hour to 75 minutes. Significant departures from these timeframes may be due to this function not being fully carried out.
Function #2: Record status of all clients.	• No such recording occurs; or • Information is inconsistently recorded across time	Client status is regularly recorded, but information logged varies in detail, undercutting its utility as an assessment snapshot (e.g., stability, availability, response to service); or	Client status (mental status/relevant behaviors & staff interaction with client) is recorded daily in some form of a log. The log should serve as a useful clinical snapshot of each individual in a given month. Ideally, the log is predated by

Table 2. Daily Team Meeting (Quality)			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	and/or does not facilitate quick, clinically useful assessment of client's status (stability, availability, response to service).	team members independently enter their own updates into the log after services have been rendered, but before the daily team meeting, making this process inefficient and likely missing the aim of providing a succinct snapshot that allows one to quickly check status across time/staff, etc.	month for each person, showing services provided, services not provided, and missed contacts. The log is available to team members so that staff can go back and review each client's brief status report if necessary.

Function #3: Daily staff schedule is based on person-centered plan-informed client schedules.[1]	• There are no client weekly/monthly client schedules; or
	• There is no evident relationship between client schedules with either daily staff schedules OR with person-centered plans; or
	• There is not enough detail in the client schedule regarding at least two of the following:
	  ◦ the specific intervention,
	  ◦ who is delivering it, and/or
	  ◦ when it is delivered.
		Client weekly/monthly schedules exist, however:
		• Daily staff (team) schedules and client schedules are misaligned, and/or are narrow in their focus on (e.g., medications and group attendance); or
		• Client schedules are weakly informed by person-centered plans; or
		• The team excessively uses location or geographic grids to determine who delivers services vs. who is the best fit for delivering that service; or
		• There is not enough detail in client schedule regarding one of the following:
		  • the specific intervention,
		  • who is delivering it, and/or
		  • when it is delivered.
			Client weekly/monthly schedules exist and these schedules serve as a bridge between the interventions listed in the person-centered plan and what is created for the daily staff (team) schedule. Client schedules are formatted and updated in a manner to capture planned interventions, who is to deliver these interventions, and when the interventions are delivered. The format is also conducive to sharing with clients so they may have a copy of their own schedule. Example: If the person-centered plan indicates attending Illness Management and Recovery (IMR) group as an intervention, that in turn is more specifically scheduled in the client schedule (e.g., listed as an activity for Wednesday from 10 – 11 with Beth, the peer specialist), and then in turn shows up as an activity for Beth to complete on the Wednesday daily staff (team) schedule.
			For full credit, client schedules exist and:
			• are formatted to be shared with clients;
			• have sufficient detail capturing the nature of the intervention, who is delivering it, and when it is delivered;
			• appear to drive the daily staff (team) Schedule content and appear to approximate interventions in the person-centered plan.

Function #4: Daily staff schedule is based on clients' emerging needs.	Team members talk about clients' emerging needs, but do not specify a plan for contacts to address those needs.	The team talks about clients' emerging needs in the daily team meeting, but is inconsistent about the extent to which they specify a plan for contacts to address those needs.	The daily staff schedule is also based on clients' emerging needs identified during staff report during the daily team meeting. Emerging needs are defined as any client needs identified during the daily team meeting that were not already scheduled to be addressed for that day based on that client's weekly /monthly schedule. Examples include: medical, dental, or other appointments not regularly scheduled based on the clients' treatment plan; and crisis response contacts and hospitalization.

[1] Use Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of weekly client schedules that match up with each client's treatment plan.

Table 2. Daily Team Meeting (Quality)			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #5: Daily staff schedule is based on the need for <u>proactive contacts</u> to prevent future crises.	The team discusses concerns in the daily team meeting without developing a plan to either address the concern in a currently scheduled contact or plan to add a contact with the client in the daily staff schedule. Teams who are not meeting consistently inherently create a communication gap resulting in poorer coordination around proactive contacts.	There is evidence that the team follows up on making proactive contacts with clients, but they are inconsistent in doing so (e.g., both types of examples were observed in the meeting). Teams that operate like individual case management teams (minimal team approach) may communicate less with each other to coordinate services overall. In such cases, it will be important to understand how well each team member is being responsive to proactive contacts on their own.	Team members consistently plan to see clients who need proactive contacts. "Proactive contacts" are preventive contacts aimed at heading off future crises. Example proactive contacts include the following: • Contact with a client before or during the anniversary of a significant event (e.g., a death of a significant other); or • Recognizing early warning signs and promptly scheduling a contact with them. <u>Note</u>: Since proactive contacts may be low frequency events, an example may not be observed in the daily team meeting during the fidelity evaluation. Thus, automatically give credit to teams for proactive contacts unless there is evidence that it is not happening (e.g., team discusses concerns without developing a plan to be proactive).
Function #6: Staff are held accountable for follow-up	There is no formal or informal mechanism for ensuring staff accountability in place.	There is a mechanism in place, but there is evidence that it is not typically followed or is not enforced when team members do not follow-up with planned contacts. Accountability may be more focused on contacts alone, not whether planned interventions were carried out.	A mechanism is in place to ensure that staff successfully complete or attempt to complete their assigned contacts each day, which ultimately holds the entire team accountable to follow-up on interventions delineated in the weekly/monthly client schedules, and those recently assigned to address emerging needs. Example mechanisms include the following: • Team leader compares the previous day's staff schedule to staff reports of previous day's contacts during daily team meeting; • Staff checks off or initials daily log or daily staff schedule after they have completed the day's assigned contacts; and • Staff communicates (e.g., email, phone) with team leader and/or team to let them know the outcome of their planned contacts that day.

	1	**2**	**3**	**4**	**5**
OS4 Daily Team Meeting (Quality)	The daily team meeting serves no more than 3 functions.	4 functions are performed at least PARTIALLY (2 are absent).	5 functions are performed at least PARTIALLY (1 is absent) OR ALL 6 functions are performed with 4 or more PARTIALLY performed.	ALL 6 functions are performed, with up to 3 PARTIALLY performed.	ALL 6 daily team meeting functions are FULLY performed.

OS5. Program Size

Definition: 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.

Rationale: The ACT team provides an integrated approach to mental health services, through which the range of treatment issues are addressed from a variety of perspectives; it is critical to maintain adequate staff size and disciplinary background to provide comprehensive, individualized service to each client.

DATA SOURCES (* denotes primary data source)

Team Survey

See team responses to item #1 regarding the number of ACT staff _____ and item #7b regarding the number of clients the team is equipped to serve at capacity _____.

Team Leader Interview*

Briefly review and confirm data regarding staffing as reported in item #1 on the Team Survey. Also clarify current capacity, which may be intentionally staggered given team development plans.	

ITEM RESPONSE CODING

Inclusion Criteria

- Count all direct service staff who meet the criteria to be included in the count for OS1[2] and psychiatric care provider staff following inclusion criteria listed below.
- For teams with more than one psychiatric care provider, each provider must be assigned to work with the team at least 0.20 FTE (i.e., 8 hours/week).
- Psychiatric Residents may also count toward the team staffing if they are assigned to the team at least 0.20 FTE (i.e., 8 hours/week) and are assigned to the team for one year.

Exclusion Criteria

- Do not count the program assistant or any other administrative staff/managers who oversee team.

Rating Guidelines and Formula

Teams that have a caseload size cap at or slightly above or below a 100-client team or 50-client team should simply use the FTE staffing level in ratings 1-5 below to determine rating.

Teams with different caseload size caps should use the grid below. Find the caseload size cap for the team being evaluated, or the next higher caseload cap shown. The criteria (i.e., ranges of required direct clinical staff FTE for each rating) are listed along that row to the right.

[2] Similar to the calculation for OS1, in order to count part time or temporary staff, they must work exclusively with the ACT team for at least 16 hours a week (0.4 FTE) and attend the daily team meeting at least two times a week.

Supplemental Grid for Teams with a Caseload Cap Different than 50 or 100 Clients					
Caseload Cap Size	**Rating**				
	1	**2**	**3**	**4**	**5**
125	Fewer than 5.5 FTE	5.5 - 7.4 FTE	7.5 - 9.4 FTE	9.5 - 11.4 FTE	At least 11.5 FTE
120	Fewer than 5.5 FTE	5.5 - 7.3 FTE	7.4 - 9.2 FTE	9.3 - 11.1 FTE	At least 11.2 FTE
115	Fewer than 5.5 FTE	5.5 - 7.2 FTE	7.3 - 9.0 FTE	9.1 - 10.8 FTE	At least 10.9 FTE
110	Fewer than 5.5 FTE	5.5 - 7.1 FTE	7.2 - 8.8 FTE	8.9 - 10.5 FTE	At least 10.6 FTE
105	Fewer than 5.5 FTE	5.5 - 7.0 FTE	7.1 - 8.6 FTE	8.7 - 10.2 FTE	At least 10.3 FTE
100	Fewer than 5.5 FTE	5.5 - 6.9 FTE	7.0 - 8.4 FTE	8.5 - 9.9 FTE	At least 10.0 FTE
95	Fewer than 5.5 FTE	5.5 - 6.8 FTE	6.9 - 8.2 FTE	8.3 - 9.6 FTE	At least 9.7 FTE
90	Fewer than 5.5 FTE	5.5 - 6.7 FTE	6.8 - 8.0 FTE	8.1 - 9.3 FTE	At least 9.4 FTE
85	Fewer than 5.5 FTE	5.5 - 6.6 FTE	6.7 - 7.8 FTE	7.9 - 9.0 FTE	At least 9.1 FTE
80	Fewer than 5.5 FTE	5.5 - 6.5 FTE	6.6 - 7.6 FTE	7.7 - 8.7 FTE	At least 8.8 FTE
75	Fewer than 5.5 FTE	5.5 - 6.4 FTE	6.5 - 7.4 FTE	7.5 - 8.4 FTE	At least 8.5 FTE
70	Fewer than 5.5 FTE	5.5 - 6.3 FTE	6.4 - 7.2 FTE	7.3 - 8.1 FTE	At least 8.2 FTE
65	Fewer than 5.5 FTE	5.5 - 6.2 FTE	6.3 - 7.0 FTE	7.1 - 7.8 FTE	At least 7.9 FTE
60	Fewer than 5.5 FTE	5.5 - 6.1 FTE	6.2 - 6.8 FTE	6.9 - 7.5 FTE	At least 7.6 FTE
55	Fewer than 5.5 FTE	5.5 - 6.0 FTE	6.1 - 6.6 FTE	6.7 - 7.2 FTE	At least 7.3 FTE
50	Fewer than 5.5 FTE	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	At least 7.0 FTE
45	Fewer than 5.5 FTE	5.5 - 5.8 FTE	5.9 - 6.2 FTE	6.3 - 6.6 FTE	At least 6.7 FTE
40	Fewer than 5.5 FTE	5.5 - 5.7 FTE	5.8 - 6.0 FTE	6.1 - 6.3 FTE	At least 6.4 FTE
35	Fewer than 5.5 FTE	5.5 - 5.6 FTE	5.7 - 5.8 FTE	5.9 - 6.0 FTE	At least 6.1 FTE
30	Fewer than 5.5 FTE	5.5 FTE	5.6 FTE	5.7 FTE	At least 5.8 FTE

	1	**2**	**3**	**4**	**5**
OS5 Program Size	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	100-Client Team: 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	50-Client Team: Includes at least 7.0 FTE direct clinical staff.

OS6. Priority Service Population

Definition: ACT teams serve a specific, high service-need population of adults with serious mental illness and are able to make decisions about who is served by the team.

(1) The team has specific admission criteria, inclusive of schizophrenia & other psychotic disorders or bipolar I disorder, significant functional impairments, and continuous high service needs, and exclusive of a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury or personality disorders.

(2) The team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.

Rationale: ACT is an evidence-based practice for people with serious mental illness, primarily those diagnosed with schizophrenia spectrum disorders, other psychosis, and bipolar I disorder. Further, given that ACT is a relatively expensive and scarce service resource, it should be available to persons whose needs for this level of intensity are greatest and who meet these diagnostic criteria. Since teams are working with clients in greatest need and who typically require tremendous staffing resources, it is imperative that there is some mechanism by which the team is involved in the decision to both admit and discharge clients from the team.

DATA SOURCES (* denotes primary data source)

Team Survey

See team responses to the following items:
#8: Does the team currently serve any clients who do NOT meet ACT admission criteria and/or are inappropriate for ACT? _____#9: Number of clients estimated to NOT meet ACT admission criteria:_____

Chart Review* - Chart Review Log Part II (p. 197-198)

Specify psychiatric diagnoses from client charts reviewed. In addition to excluding clients with diagnoses inconsistent with the definition for criterion #1 (please see above), consider excluding those who have not otherwise specified (NOS) diagnoses when the prevalence of such diagnoses appears to be high. If, after conducting the chart review, several individuals have diagnoses that are questionably appropriate for ACT, consider requesting a complete list of all clients' psychiatric diagnoses to guide rating for this item.

Team Leader Interview*

Based on your response to the Team Survey, you indicated that approximately ____ people do not meet ACT admission criteria or are inappropriate for ACT. ***Please tell me more about these individuals*** (if reported to be "0," inquire as to how it is none)***.*** [Prompt for any clients who have a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury, or personality disorder. If chart review data indicate a higher number of clients with diagnostic profiles questionably appropriate for ACT, then ask the team leader if they can generate a report on all clients' diagnoses so that criterion #1 can be rated using a full sample]	

What is the current process for screening referrals? Can you walk us through the "life of a referral"? ***What happens if you think a referred client is inappropriate for ACT?*** ***Do you generally feel like you have control over admissions? Why or why not?*** ***Is there a way to discharge clients you think are inappropriate for ACT once you've admitted them to the team?*** [If yes] *Can you describe this process?*	
Clinician Interview	
Are there current ACT clients you feel do not meet the admission criteria? [If yes:] *Why do you think they are inappropriate?* [Differentiate between those who had been inappropriate throughout vs. those who became inappropriate due to some recovery.]	
Psychiatric Care Provider Interview	
Who are the most appropriate clients for ACT? ***Can you give us examples of clients who would not be appropriate for ACT?*** [You are not necessarily seeking specific client examples, but example client symptoms, behaviors, functioning, scenarios that may reflect someone needing a less intensive or even more intensive service than ACT.] ***What is your role in making sure the team is serving those who most need ACT services?***	

ITEM RESPONSE CODING
Rating Guidelines
Cross-reference team leader interview and chart review (primary data sources) with the clinician interview. Rate criterion #1 based on chart review data, unless team can report on diagnostic data across clients. Please refer to Table 3 below to determine credit.

Table 3. Priority Service Population

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team has specific admission criteria, inclusive of schizophrenia, other psychotic disorders, bipolar disorder I, significant functional impairments, continuous high service needs, exclusive of a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury, or personality disorders.[3]	**Chart review client sample**: More than 20% of clients do not meet diagnostic admission criteria. OR **All clients:** More than 10% of clients do not meet diagnostic admission criteria.	**Chart review client sample**: 80-89% of clients selected for chart review meet diagnostic admission criteria. OR **All clients:** 90-94% of clients meet diagnostic admission criteria.	**Chart review client sample**: 90% or more of chart sample meet diagnostic admission criteria. OR **All clients:** 95% or more meet diagnostic admission criteria.
Criterion #2: The team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.	The team is not the gatekeeper for admission and discharges and may be compelled to admit clients who are not appropriate for ACT (i.e., there are few options for appealing or rejecting referrals to the team).	The team reports that they are the gatekeeper for admissions and discharges, yet there appear to be some exceptions (e.g., they report instances when they felt like they were "forced" to admit an inappropriate client). Alternatively, team may have less gatekeeper authority, but have an appeal process that bolsters their position to have a final say on who it is they serve.	The team indicates that they generally provide the final say in admissions to, and discharges from, the team, and there is typically minimal external pressure to admit or keep clients on their caseload.

	1	2	3	4	5
OS6 Priority Service Population	The team at least PARTIALLY meets criterion #2 only OR does not meet either criterion.	The team PARTIALLY meets criterion #1 only.	The team PARTIALLY meets criterion #1, and at least PARTIALLY meets criterion #2.	The team FULLY meets criterion #1, and PARTIALLY meets criterion #2.	The team FULLY meets both criteria.

[3] Use Chart Review Tally Sheet I or TMACT Calculation Workbook to calculate the percentage of clients who did not appear to be appropriate for ACT given their diagnostic profile.

OS7. Active Recruitment

Definition:
(1) The team (or its organizational representative) actively recruits new clients who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team.
(2) The team is primarily comprised of clients from referral sources and sites outside of usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach).
(3) The team works to fill open slots when they are not at full capacity and/or the client-to-staff ratio is well below 10:1 on more mature teams.

Rationale: ACT is best suited for clients who do not effectively use less intensive mental health services. Reliance on passive approaches to client recruitment using typical mental health organizational intake systems or internal referrals does not typically ensure that the most suitable persons are served. Teams typically need to actively recruit in community settings outside of a parent agency to ensure that ACT services are offered to persons in their region who are most suited to using them. Since ACT is also a scarce resource, it is important for teams to work at full capacity.

DATA SOURCES (* denotes primary data source)

Team Survey*

Item #7a: Number of clients currently enrolled on the team: _____

Item #7b: Number of clients the team is equipped to serve at capacity (Clarify current capacity, which may be intentionally staggered given team development plans): _____

Item #10: Current number of clients who had been "stepped up" from less intensive services within the agency when they were referred to ACT: _____

Team Leader Interview*

Who makes referrals to the team?	
What recruitment procedures do you use to find clients for the ACT team, especially those <u>most</u> in need of this service? *In what ways does the team conduct outreach and engagement for recruiting new clients or collaborate closely with separate outreach programs? What venues are visited for outreach (prompt for a range of places, including shelters, jails, other homeless outreach programs)?* (If the team is at capacity, and therefore is hesitant to actively seek out individuals who may need ACT but who would end up waitlisted, is there evidence that the team works to maintain relationships and warm contacts at potential referral sites [e.g., can they name warm contacts at various sites, do they have an advisory board or steering committee with representatives from potential referrals sites, etc.])?	
How many open slots are there on your team?	

ITEM RESPONSE CODING
Rating Guidelines
Use the team leader interview and survey as primary data sources for rating. Please refer to Table 4 to determine if criteria are met at all, partially, or fully. NOTE: If the ACT team shares outreach and recruitment services within a parent agency or there is another mechanism by which referrals occur (e.g., a managed care organization), evaluate these collective efforts.

Table 4. Active Recruitment			
Criteria	**Examples/Guideline**		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team (or its organizational representative) actively recruits new clients who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team.	The team does not build relationships with relevant referral sources; existing relationships are only happenstance and not actively maintained.	**The team is not at capacity**, and the team is sporadic with their recruitment activities (e.g., focusing solely on one or two single sources, not fully canvassing their area for relevant referral sources). **The team is at capacity**, and there is weak evidence for the team's persistence in maintaining warm relationships with relevant referral sources, and/or the team has no organized mechanism for prioritizing admissions to the team.	**The team is not at capacity**, and the team regularly visits specific referral sources for outreach and relationship-building, to include community inpatient units, emergency and crisis programs, jails, shelters, and, where available, system-wide community meetings where various referral sources meet regularly. The team conducts regular screening and planning for new admissions. Non-ACT staff (e.g., local government entity, or agency administration) may perform these outreach functions on behalf of the team; however, the team must still actively build and maintain relationships with common and/or anticipated referral sources. **The team is at capacity**, and there is a mechanism for prioritizing admissions to the team (e.g., waiting list) to ensure that new clients can be admitted to the team once there is an open slot. Also, if at full capacity, there may be less of a need to conduct community outreach for the purpose of identifying potential ACT clients, but there is clear evidence that the team has developed and actively maintains positive relationships with referral sites (e.g., can name "warm contacts" at various referral sites, such as local shelters, jail, hospitals, other non-profit organizations, etc.).
Criterion #2: The team is primarily comprised of clients from common referral sources and sites outside of usual community mental health	Less than 50% of clients were referred from outside agencies/referral sources or a more	50 - 74% of clients served by the team were referred from outside	The team caseload is comprised of at least 75% of clients from outside agencies/referral sources or from within more restrictive programs administered by the parent agency (e.g., mobile crisis

Table 4. Active Recruitment			
Criteria	**Examples/Guideline**		
	No Credit	**Partial Credit**	**Full Credit**
settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach) or more restrictive agency programs.[4]	restrictive program within the parent agency vs. less restrictive programs within the parent agency.	agencies/referral sources or more restrictive programs within the parent agency.	team, critical time intervention) vs. less restrictive programs administered by the parent agency (e.g., adult case management program).
Criterion #3: The teams work to fill open slots when they are not at full capacity and/or the client-to-staff ratio is well below 10:1 on more mature teams.	The team has fewer than 90% of slots filled.	The team has 90-94% of slots are filled.	At least 95% of slots are filled. If the team is at least two years old, the client-to-staff ratio is no less than 6:1. **Note**: It is important to clarify with team what their current, not ultimate, caseload cap is.

	1	**2**	**3**	**4**	**5**
OS7 Active Recruitment	The team PARTIALLY meets 1 criterion or less.	1 criterion is FULLY met (2 are absent) OR 2 criteria met, with both criteria PARTIALLY met OR 1 criterion is PARTIALLY met and 1 FULLY met (1 is absent).	2 criteria are FULLY met (1 is absent) OR ALL 3 criteria are met, with 2 or 3 PARTIALLY met.	ALL 3 criteria are met, with 2 FULLY and 1 PARTIALLY met.	ALL 3 criteria are FULLY met.

[4] See the Team Survey response #10 to calculate the percentage of clients referred from less restrictive programs within the agency.

OS8. Gradual Admission Rate

Definition: The team admits new clients at a low rate to maintain a stable service environment.

Rationale: To provide consistent, individualized, and comprehensive services to clients, a low intake rate is necessary. Taking on too many new clients at once can be disruptive to the services that current clients receive and contribute to staff stress and burnout.

DATA SOURCES (* denotes primary data source)

Team Survey

See item #11: Highest number of admissions per month in the past 6 months: _____

Team Leader Interview*

Briefly review and confirm number of admissions reported in the Team Survey item #11.	

Excel spreadsheet (Second column)

Cross-check the number of clients the team indicated as having enrolled in the team within the past 90 days with their reported highest enrollment in a single month in the past six months (i.e., no more than 12 individuals should be noted as recent enrollees if team did not exceed four per month; inquire about apparent discrepancies).

ITEM RESPONSE CODING

Rating Guidelines

If the highest monthly intake rate during the last six months was no greater than four clients, the item is rated as a "5."

NOTE: A team may receive some pressure to enroll a higher number of people in a short amount of time, such as when a new team is building to a capacity, or is absorbing another team's caseload. Although this information may guide feedback in the report, it should not alter the rating itself.

Notes:

	1	2	3	4	5
OS8 Gradual Admission Rate	Highest monthly admission rate in the last 6 months is greater than 15 clients per month.	12 -15	8 - 11	5 - 7	Highest monthly admission rate in the last 6 months no greater than 4 clients per month.

OS9. Transition to Less Intensive Services

Definition:

(1) The team conducts a regular assessment of the need for ACT services;
(2) The team uses explicit criteria or markers to assesses 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.

Rationale: Although some individuals may experience an increase in symptoms and greater functional impairments without ACT, therefore requiring longer-term ACT services, many individuals also get better over time and are able to graduate from ACT to a less restrictive community program. As supported by research, programs should have an explicit process for assessing the appropriateness of graduation and for making the transition for those ready to graduate.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to response to item #12. Note whether the team has transitioned any clients to less intensive services in the past year: _____

Team Leader Interview*

[If there were no transitions to less intensive services in the past year, then ask the following and then continue with remaining questions]: ***I see you didn't have any transitions to less intensive services over the past year. Why do you think that is? How many transitions did you have the prior year?***	
[If there were transitions, inquire about those clients when asking below questions.]	
How do you assess clients in their readiness to graduate from ACT because they are doing better? *On what basis do you determine ongoing need for ACT services? Can you summarize any established criteria that help you to determine whether someone is ready for transition to less intensive services? How often do you conduct these assessments?*	
What process do you follow to transfer clients to less intensive services? [Prompt for whether they gradually transition clients, how much contact they have with the transition program, whether they continue to follow clients after transition from ACT and if so, for how long.]	

Can you describe a typical transition plan? [Prompt for gradually decreasing number of visits, more office-based contacts, seeing fewer team members, picking up medications at the pharmacy.] ***To what services do clients transition? Under what circumstance would the team maintain contact with clients and/or the new service provider following transition? For how long?*** [Probe for whether contacts with clients were team or client initiated; probe for how it is determined which clients get more extensive follow-up.] ***If a previously graduated client needs to return to the team, what would that process entail? When would the team commence services?*** [Prompt for the following: *Are they put back on the waitlist first or quickly re-admitted? Can the team begin serving the participant without immediate assurance of payment?*] ***In the past two years, can you think of a client whose transition process best reflected the work of the team, and summarize the team's work with us?***	
Clinician Interview	
When do you start discussing transition from ACT with clients? ***What markers or indicators for transition are you assessing and considering?***	

If clients have transitioned from your team to less intensive services, how was that decision made? [Probe for assessment criteria used and whether there were any external initiatives or pressures that played a role in the decision to transition specific clients.] ***To what services did they transition? Under what circumstance would the team maintain contact with clients and/or the new service provider following transition? For how long?*** [Probe for whether contacts with clients were team or client initiated; probe for how it is determined which clients get more extensive follow-up.]	

ITEM RESPONSE CODING

Rating Guidelines

See Table 5 to determine if criteria were met at all, partially, or fully. Use the team leader interview as the primary data source. Cross-reference with information from the chart review and clinician interview.

Rating guidelines for teams that do not identify any clients who have transitioned to less intensive services over the past two years: If the team has not transitioned anyone in the past two years, it may be due to their current stage of development (newly implemented teams) or due to their not meeting criterion #1 and/or #2. If no recent examples of transition to less intensive services are available, assess criteria #3-5 based on the team leader's response to what the team plans to do when they transition clients from the team to less intensive services. Do they have a specific protocol or policies on how to handle these transitions, including gradual transition, continued follow-up, and re-admission to the team, if needed? For established teams that have not transitioned anyone, there should be compelling data speaking to intentions if considering ratings higher than partial rating criteria.

Table 5. Transition to Less Intensive Services

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team conducts regular assessment of need for ACT services.	The team does not assess for transition readiness. Recent transitions did not result from the team's proactive assessment efforts.	The team does assess for the clients' need for ACT services, but this practice is not systematic and/or formalized (e.g., or no documentation is made or not tied to established processes around planning and authorizations).	Team members regularly assess for client readiness for transition to less intensive services, including improvement across areas of clinical and role functioning, as indicated in client charts. To further support "full credit" practice, one or more of the following are noted: • The team includes a discussion about clients' readiness for transition from ACT as part of their regular treatment plan reviews. This is supported by documentation in the charts; and/or

Table 5. Transition to Less Intensive Services			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
			• The team may use a level of care system to categorize client readiness for transition and regularly review as a team or in each ITT;
Criterion #2: The team uses explicit criteria or markers for need to transfer to less intensive service option.	The team is not able to present relevant and explicit criteria or markers indicating a need to transfer to less intensive services.	Transition readiness criteria do not appear to be explicit (e.g., inconsistent reports across team members). OR, the criteria themselves have questionable utility (e.g., narrowly focusing on medication adherence and hospitalizations only). They may complete a standardized assessment tool, but it isn't used to guide routine review.	Criteria need to be well-specified so that all team members would be able to objectively identify when a client is ready for transition to less intensive services. Ideally, a standardized assessment tool is used to guide routine review. Markers or criteria may include the following: • Use of fewer or less intensive services such as hospitals or emergency rooms; AND • More independent functioning and/or improvement in major domains (e.g., housing, treatment participation, psychiatric medication use, psychiatric hospitalization/crisis management, forensic involvement, substance use, high-risk behaviors, ADL, community integration).
Criterion #3: Transition is gradual & individualized, with assured continuity of care.	Transitions appear abrupt and there is little effort to promote continuity of care.	There is little time between identifying client as ready for transition and actual transition, and/or efforts to prepare client and lay road for service continuity are lacking (e.g., there is limited contact with the transition service provider before the client is discharged). The process itself is not individualized; there is a one size fits all approach. Also, transitions may appear unnecessarily long for most clients.	Period between identification of transition readiness and actual transition should be individualized, considering the need for time to prepare for the transition (e.g., three to six months), while also not unnecessarily prolonging transition. Examples of gradual individualized transitions include: • Gradual transition may begin with a "Transition Group" within the ACT team, comprised of other ACT clients who are getting ready for transition from ACT to less intensive services. • Client may try out services in another program for brief periods of time (e.g., a few hours or one day) while still receiving ACT services. • Team should have some mechanism for communicating with transition service provider to ensure continuity of care.
Criterion #4: Status is monitored following transition, per individual need.	The team does not monitor client status following transition. Communications with the team appear to be initiated primarily by the client	Monitoring of clients' status following transition appears to be inconsistent (e.g., examples are limited, and/or primarily reflect clients' initiating contact with the team). OR	The need for post-discharge monitoring will vary across clients. However, it is assumed that at least some will clearly benefit from such follow-up. • Team continues to communicate with transition service provider regarding client's status (e.g., up to three months). Note: These do not have to be formal meetings, but there needs to be at least some form of checking in on the client's status.

Table 5. Transition to Less Intensive Services			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	and/or transition provider.	Teams take a one size fits all approach to follow-up (e.g., every client is followed for up to three months regardless of need)	• If needed, team members visit client to assess status in less intensive services after transition from ACT.
Criterion #5: The team expedites re-admission to the team if necessary.	Once discharged, previously served ACT clients are not able to re-enroll; OR they must follow typical enrollment procedures. Enrollment is not expedited; OR the team is precluded from re-admitting the client because of larger system barriers (e.g., the client no longer meets admission criteria even though returning back to the team, even for a brief period, would be helpful to him or her).	Policies and procedures are in place to expedite re-enrollment, however there still appears to be considerable lag time (e.g., these clients are moved to the front of the waitlist, but can remain waitlisted for months); OR Clients who transition to less intensive services have the option to return to the team, depending on whether the team is at full capacity at the time.	Re-enrollment of formerly transitioned clients should be expedited. The team may reserve one-to-two slots for re-enrollment of clients who transition from the program for a limited period (e.g., three months post-discharge from ACT); and/or • Former ACT clients who need to be re-admitted do not have to be placed on a waiting list (e.g., the team is able to exceed capacity to accommodate a client who needs to be re-admitted). • Where ACT eligibility criteria are listed, recently transitioned clients may return to ACT even if not meeting listed entrance criteria.

	1	**2**	**3**	**4**	**5**
OS9 Transition to Less Intensive Services	Up to 1 criterion is met OR 2 criteria are met, with 1 or 2 PARTIALLY met.	2 criteria are FULLY met (3 are absent) OR 3 criteria are met, with 1 to 3 PARTIALLY (2 are absent).	3 criteria are FULLY met (2 are absent) OR 4 criteria are met, at least PARTIALLY (1 is absent).	4 criteria are FULLY met (1 is absent or only partially met).	ALL 5 criteria are FULLY met.

OS10. Retention Rate

Definition: The team retains a high percentage of clients given that they enroll clients appropriate for ACT, utilize appropriate engagement techniques, and deliver individualized services. Referral to a more restrictive setting/program would normally be considered an adverse outcome.

Rationale: Teams that admit the intended population for ACT and are serving them well (i.e., engagement, building rapport, meeting service needs) should be able to retain the vast majority of their caseload within a year's time. Discharges to other institutional settings (e.g., hospitals, nursing homes, group homes) may be warranted in some cases, but may also reflect poor selection, engagement, and service provision. A low retention rate can also reflect broader systemic issues beyond the control of the team, such as an external authority insisting the team serve individuals who may not be appropriate for ACT or a managed care company denying authorization for ACT services for clients who clearly need ACT.

DATA SOURCES (* denotes primary data source)

Team Survey*

Refer to responses on the following survey items, and transfer to Table 6 below:

#7a: Number of clients currently enrolled: _____
#7c: Number of clients enrolled one year ago: _____
#12: Number of clients discharged from the ACT team for listed reasons: _____

Team Leader Interview*

Tell me more about those clients listed who were transferred to more restrictive settings due to medical, health, or safety reasons. What was the team's role in that process? [Note: The default is to include all clients within the numerator count (i.e., 'drop-outs'), however evaluator may judge to not count select cases if it is very clear that the clients' transfers were due to legitimate clinical/health reasons that exceeded the team's ability to appropriately care for their needs.]	
Please tell me more about any others listed on the survey who were discharged (not due to death or graduation). What was the team's role in that process? [If anyone is listed as discharged due to an authorization denial, clarify if team went through an appeals process]	
Were any of the individuals listed as being discharged later re-admitted to the team (e.g., re-enrolled following release from jail)? [Exclude from the final drop-out count anyone who has since been re-admitted to the team.]	

ITEM RESPONSE CODING			
Inclusion and Exclusion Criteria (Refer to Table 6, cross-walking and confirming Team Survey data):			
Table 6. Retention Rate Calculation: Who Constitutes a "Drop Out"?			
Reason for Discharge/Disenrollment in the Past Year:	**Considered a "Drop Out"?**	**Transferred Team Survey Item #12**	**Final "Drop Out" Count**
Unable to locate client	YES		
Incarcerated	YES (exclude if person is since re-enrolled to team)		
Discharged as a result of not receiving authorization from managed care organization	YES. Exception is up to one client may be excluded as a "drop out" if there is convincing evidence that the team put forth significant effort to appeal the authorization denial.		
Transferred to a more restrictive service setting (e.g., hospital, nursing home, residential treatment center)[2]	YES. Exception is if there is convincing evidence that the client had significant medical needs and/or safety concerns that went beyond the team's *reasonable* ability to address.		
Refused services and/or requested discharge	YES		
Moved out of service area	YES. Exception is if the team had knowledge of the move and assisted with the service transfer.		
Other (specify):			
Transitioned to less intensive services/graduated	NO	n/a	n/a
Deceased	NO	n/a	n/a
Formula	$1 - \left[\frac{\text{\# client "Drop-Outs" in the past year}}{(\text{\# clients currently enrolled} + \text{\# clients enrolled 1 year ago}) / 2} \right] \times 100$		
Rating Guidelines			
	Refer to data provided in the Team Survey (items 7a, 7c, and 12). Reference these numbers when asking the team leader for a description of each client who left the team. Then determine who constitutes a drop out by using Table 6 and the formula above.		

	1	2	3	4	5
OS10 Retention Rate	Less than 65% of the caseload is retained over a 12-month period.	65 - 76%	77 – 86%	87 - 94%	95% or more of caseload is retained over a 12-month period.

OS11. Involvement in Psychiatric Hospitalization Decisions

Definition: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating a crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the client during their hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning).

Rationale: To ensure more appropriate use of psychiatric hospitalization and continuity of care, it is essential for the ACT team to be involved in hospitalization decisions and processes, which includes efforts to help the client avoid hospitalization by accessing other less restrictive alternatives and facilitating appropriate admissions. Ongoing ACT team participation during a client's hospitalization and discharge planning allows the team to help maintain community supports (e.g., housing) and continuity of service in the community.

DATA SOURCES (*denotes primary data source)

Team Survey*

Refer to item #14 and extract the last ten psychiatric hospitalization events. An "event' is defined as either an admissions or discharge from a psychiatric hospital.

Team Leader Interview*

Tell me more about the team's involvement in the last ten hospitalization events.

[Go through each of the most recent client psychiatric hospitalization events reported in the Team Survey and determine what role the team played in each by using Table 7 for guidance on whether to give credit for team involvement in each admission or discharge. Use below Table 7 to record the last ten events (e.g., #5 Admission; #5 Discharge; #7 Admission; #8 Admission; #8 Discharge) and then note if credit was granted or not given description.]

Table 7. Examples of Team Involvement with Psychiatric Hospitalization Decisions		**Client ID & Event Type**	**Credited**	**Not credited**
Hospital Admissions	• Activating a crisis plan to employ alternative strategies before resorting to hospitalization • Assessing need for hospitalization • Actual facilitation of hospitalization (voluntary or involuntary) • Coordinating with natural supports or other providers to determine need for hospitalization, which was then facilitated by others • Consulting with hospital staff at time client presents for admission • Providing on-site evaluation of the client at the time of presentation to the ER • Prompt contact with hospital staff upon learning that the client had been hospitalized (within 24 hours of admission) to help coordinate care			
Hospital Discharges	• Involvement in the coordination of care/visiting the client during his or her stay • Assessing readiness for discharge • Coordinating dispositional placement (i.e., housing), discharge medications/services • Actual facilitation of discharge, including transportation from the hospital			

ITEM RESPONSE CODING
Inclusion Criteria
Include all psychiatric hospital admission and discharge events in this count. An "event" is defined as either an admission or a discharge from the hospital.
Rating Guidelines
Use the team leader interview and your review of the ten most recent psychiatric hospitalization events reported in the Team Survey as the primary data sources for rating this item. Please refer to Table 7 to judge whether the team's report of involvement in each hospitalization event is counted in this rating. If team involvement does not reflect a range of efforts to coordinate and/or facilitate psychiatric hospitalization admissions (e.g., primarily just being responsive within 24 hours of client admission) or discharges (e.g., only providing transportation home from the hospital), with no other examples, rate down by one score. Use some discretion in determining which "events" are considered (e.g., a transfer from one hospital to another hospital may not need to count as two distinct events for this item – one discharge to another admission).

	1	2	3	4	5
OS11. Involvement in Psychiatric Hospitalization Decisions	The team is involved in fewer than 15% of admissions & discharges.	The team is involved in 15% - 44% of admissions & discharges.	The team is involved in 45 - 69% of admissions & discharges.	The team is involved in 70% - 89% of admissions & discharges.	The team is involved in 90% or more admissions & discharges.

OS12. Dedicated Office-Based Program Assistance

Definition: The team has 1.0 FTE of office-based program assistance available to facilitate the day's operations in a supportive manner for the team, clients, natural supports, and other ancillary service providers (e.g., landlords, social security). Primary functions include the following:

(1) Providing direct support to staff, including monitoring & coordinating daily team schedules and supporting staff both in the office and field;
(2) Serving as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports; and
(3) Actively participating in the daily team meeting.

Rationale: ACT services are primarily community-based and team activities may change based on emerging client service needs. As a result, it is important for there to be a staff function to include centralized, office-based communication and coordination across team members and clients to promote continuity of care.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to item #1 before interviewing team leader, noting whether the team currently has 1.0 FTE program assistant assigned.

Team Leader Interview* or Program Assistant

[Clarify how many people share this role, especially if it appears to be shared across staff in a given day. Also clarify the extent to which the person dedicated to this role has other responsibilities, especially those that are non-ACT program activities and/or involve community-based work.] ***Is someone available in the office during the day, such as a program assistant and/or shift manager?*** [If yes]: ***What is their role on the team?*** *To what extent does this person act as a liaison between team members and clients/their natural supports? What about among team members—does this role help them to stay in touch throughout the day?* ***If (team member) is out in the field assigned to see a client who really needs to be seen, but that client is not home at the time, what steps, if any, would the team member take next?*** [Listen for the extent to which the team member relies on the office-based person to help with rescheduling that contact, such as with another team member who is in that area later in the day.]	

How many hours a day/days a week, is someone available to serve in this capacity? [This may be a straightforward FTE if an office-based program assistant dedicated to the team. If the team uses a shift manager, it is important to determine the estimated FTE for this role.] ***Does this person participate in the daily team meeting*?** [If yes]: ***How often and what role do they serve at the meeting?*** *[Can you give me examples of where the program assistant also provided updates during the meeting, such as phone calls received, encounters with clients or natural supports, etc.?]* [If no]: ***Do you ever give the program assistant important clinical updates based on reports in the daily team meeting?*** [Seek examples]	

Direct Observation

During the process of conducting the fidelity review, it is likely that there will be many opportunities to observe the role of the program assistant and to directly interact with them. Pay attention to the extent to which the program assistant fulfills all specified roles over the course of the review

ITEM RESPONSE CODING

Rating Guidelines

Use Table 8 to determine whether the criteria for this item are met fully or partially.

- The team has 1.0 FTE office-based program assistance. More than one staff person may fulfill the function; however, no more than two staff are appointed to fill this role each day (i.e., the role should not be divided among several staff over the course of one day).
- If two people fill this role, assess based on the extent to which an adequate communication mechanism is in place between these two people to ensure continuity of coordination and care. Note that the minimal team inclusion expectations described in OS1 may not apply here.
- The designated program assistant should be *office-based* so that both functions are adequately fulfilled.
- Meeting these functions is the primary responsibility for the designated program assistant, not secondary to other administrative responsibilities.
- Do not count if the program assistant is technically employed by the team but has been on extended leave for three months or more.

Table 8. Dedicated Office-Based Program Assistance			
Functions	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Provides direct support to staff, including monitoring & coordinating daily team schedules and supporting staff in the office and field.	There is no team member providing program assistance or their role is primarily administrative or clerical.	Team member(s) providing program assistance sometimes provide direct support to staff, but are less consistent in this role. Some administrative or clerical duties may take priority; fulfilling this function is secondary to administrative and clerical tasks.	This office-based team member has a role in developing and/or managing the daily staff schedule and updating it based on reports in the daily team meeting as well as staff vacations/leave. They take responsibility for assisting team members with various clients' appointments and case management tasks, such as arranging clients' medical and housing appointments and working with landlords. They also assist and support field-based staff (e.g., rescheduling another staff to see a client who is absent during contact; looking up address for a client doctor's appointment). Meeting this function is the primary responsibility for the designated program assistant, not secondary to other administrative or clerical responsibilities.
Function #2: Serves as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports.	There is no team member providing program assistance or their role is primarily administrative or clerical.	Team member(s) providing program assistance sometimes work with clients and supports by phone and in-person, but are less consistent in this role. Some administrative or clerical duties may take priority; fulfilling this function is secondary to administrative and clerical tasks.	This office-based program assistant actively works directly with clients and natural supports by phone and in-person. The team relies on program assistant to be in the office to attend to emerging needs throughout the day. Examples include the following: • Responding to walk-ins, including figuring out medication refills with the team nurses and disbursement of funding; • Handling calls from clients' family members and natural supports; or • Contacting other team members when needed to assist with response to walk-ins and/or phone calls or to update them.
Function #3: Actively participates in the daily team meeting.	Team member(s) providing program assistance do not regularly attend the daily team meeting. Rating cannot be higher than a "3" on this item.	Team member(s) providing program assistance on the team regularly attend the daily team meeting, but do not take an active role (e.g., sits to the side taking notes or documenting in the log, but not reporting on contacts with clients).	Team member(s) providing program assistance on the team are engaged and contribute to the daily team meeting on a regular basis. They report on recent contacts with clients and natural supports in that meeting. They may also play a role in updating the log, daily staff schedule, or other tools/paperwork related to planning program contacts.

	1	**2**	**3**	**4**	**5**
OS12. Dedicated Office-Based Program Assistance	Less than 0.50 FTE program assistance is available to the team OR 0.50 - 1.0 FTE program assistance is available, but not meeting rating "2" performance.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing 2 functions OR 1.0 FTE program assistance is available and performing 1 function ONLY.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing ALL functions OR 1.0 FTE program assistance is available, at least PARTIALLY performing 2 functions.	1.0 FTE program assistance is available, at least PARTIALLY performing ALL functions.	1.0 FTE program assistance is available, FULLY performing ALL functions.

CT1. Team Leader on Team

Definition: The team has 1.0 full-time (i.e., works 40 hours a week) team leader with full clinical, administrative, and supervisory responsibility to the team. The team leader has no responsibility to any other programs during the 40-hour workweek. The team leader must have at least a master's degree in social work, psychology, psychiatric rehabilitation, or a related clinical field, a license in their respective field, and at least three years of experience in working with adults with severe mental illness. Team leader cannot fill more than one role on the team.

Rationale: This key position on the team requires 100% devotion to the ACT program without responsibility to other service programs. To effectively lead the team in providing high quality clinical care, the team leader is expected to be a trained clinician. More advanced clinical training typically occurs during graduate-level education. State licensure and/or certification in one's clinical field helps to ensure that a minimal standard of training and knowledge of practice and ethics has been met and is being maintained with license renewals.

DATA SOURCES (* denotes primary data source)

Team Survey*

Refer to responses on item #1 related to the team leader's educational degree, licensure status, level of training, and experience in working with this population.

Team Leader Interview

Do you have any agency responsibilities outside of the ACT team (e.g., screening potential agency enrollees across programs, triaging with hospital staff for all agency clients, providing therapy to non-ACT clients)? *If so, please estimate how much of your time is spent in those activities in a given week.* [Clarify the extent to which these non-ACT activities detract from ACT responsibilities, and adjust FTE accordingly, as opposed to non-ACT activities conducted in addition to ACT responsibilities, resulting in a 40+ hour work week with no clear indications that ACT responsibilities are negatively affected.]	
Do you currently fulfill another position or role on the team (e.g., filling in for another staff vacancy)?	

ITEM RESPONSE CODING
Rating Guidelines
The team leader position is assumed by only one person. Minimal qualifications: Master's degree in social work, psychology, psychiatric rehabilitation, or a related field. At least three years of experience working with individuals with severe mental illness. To rate a "5," the team leader must also be licensed within their respective clinical field (note that provisional licenses do not count as meeting minimal qualifications). Full-time commitment to the team: One individual assigned to work full-time (40 hours a week) with the team, with virtually no commitments to agency endeavors/services unrelated to ACT (e.g., less than two hours a week). Estimate actual FTE committed to the team given other non-ACT agency responsibilities. If the team leader's time is split between team leader and another team member's roles (e.g., nursing activities, integrated treatment for COD) due to staff shortages, estimate FTE time given actual commitments to those other non-team leader roles. Reduce FTE to rate this item and credit appropriately in another item (e.g., ST5. Role of Employment Specialist in Services), if applicable. Note that some specialty functions, such as integrated treatment for COD, may be an appropriate use of direct clinical time and should not count against team leader's FTE. ***Special case:*** Do not count if they are technically employed by the team but have been on extended leave for three months or more.

	1	2	3	4	5
CT1. Team Leader on Team	Less than 0.25 FTE team leader OR less than 0.75 FTE team leader with inadequate qualifications.	0.25 - 0.74 FTE team leader who meets at least minimal qualifications.	0.75 - 1.0 FTE team leader who does not meet minimal qualifications for education and experience	0.75 – 0.99 FTE team leader who meets at least minimal qualifications OR 1.0 full-time team leader who meets all qualifications except having a clinical license.	1.0 FTE team leader who meets at least minimal qualifications, including licensure, and has full assigned responsibility to the team.

CT2. Team Leader is Practicing Clinician

Definition: In addition to providing administrative oversight to the team, the team leader performs the following functions:

(1) Directly providing services as a clinician on the team; and
(2) Delivering consistent clinical supervision to ACT staff.

Rationale: Research has shown that a practicing team leader is strongly related to better client outcomes. Clinical supervision has also been found to be a critical element of successful uptake and sustainability of evidence-based practice (EBP). Team leaders who also have direct clinical contact are better able to model appropriate clinical interventions and provide quality supervision, as well as remain in touch with the clients served by the team.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to the response to #5 and note how many hours per week team leader spends providing direct services:_____

Refer to the response to #6 and note how often the team leader provides clinical supervision to the two staff most in need, and seek to confirm if meeting with those two team members: _____

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 is typical (e.g., exclude a week in which the center was undergoing JCAHO or CARF accreditation).

Supervision Records*

Examine documentation of supervision provided by the team leader, including supervision records and previous sign-up sheets that staff use to specify their need for supervision.

Team Leader Interview

I see that you reported *(# of hours of direct clinical work).* **How did you come to calculate this number?** [If the number is clearly high (8+ hours), inquire how it came to be so high. If clearly low (under five hours), inquire why it is so low.]	
Are you assigned as the "primary" care provider or coordinator for any of the clients, or serve on ITTs?	
[If yes]: ***For how many? How was it decided that you would serve as the primary for these clients (e.g., individuals who needed more psychotherapy), or on their ITTs?*** [This additional information provides context for the number of direct hours reported in Team Survey.]	

Tell me about your approach to clinical supervision. *How often do you provide it? How long is it typically provided each time? What tends to be the focus of supervision?* [Parse out the time spent during brief, drop-in supervision vs. scheduled time and impromptu supervision that is at least 20 minutes in length.] [Refer to the staff names on the Team Survey reported to receive the most supervision.] ***What does supervision look like for [insert name]?*** *Where does it take place? Is it scheduled? How often does it occur? Does it occur in a group or individually?* [Prompt for how well targeted the team leader's overall plan for supervision is, including titrating effort and attention according to need and capacity, how they ensure that supervision needs are met within the team (in a group or individually), and whether supervision is always directly undertaken by the team leader.] ***What areas of education or training do you think would be helpful for you to do an even better job in your role?***	
Clinician Interview	
Tell me about the type of clinical supervision you typically receive from the team leader.	

COD/Employment Specialist/Peer Specialist Interviews	
Tell me about the type of clinical supervision you typically receive from the team leader.	

ITEM RESPONSE CODING

Inclusion Criteria

Rating for Direct Services:

Give more weight to the actual records than the verbal report, unless records are unavailable.
If there is a discrepancy, then ask the team leader to help you understand it.

Direct service hours may include the following:

- Face-to-face contacts with clients and/or natural supports, whether alone or with other staff;
- Phone contacts with clients and/or natural supports;
- Team leader participation in treatment planning meetings in which a client and/or natural support is present; and
- Team leader participation in initial and comprehensive assessments.

Note: An excessively high number of direct service hours (e.g., 16+ hours per week) does not necessarily reflect best practice, as it indicates that the team leader is employed more as a direct care staff than a team leader, administrator, and supervisor. If a high number of hours are reported, inquire for the reason and provide qualitative feedback in the report. An excessive amount of time spent directly providing services will likely be reflected in lower ratings on other items, including this one (e.g., decreased supervision time).

Rating for Supervision:

Base rating on how much and what type of supervision the team leader provides to the two staff to whom they consistently see for supervision. The team leader gets full credit for weekly supervision if they are either providing group and/or individual supervision to these two staff on a weekly basis.

- The team leader is expected to provide some type of supervision every week, regardless of format and coverage (e.g., group or individual).
- All team members should be receiving regular direct supervision.
- Please note that if the team has an Assistant Team Leader, supervisory responsibilities should not be completely delegated to the Assistant Team Leader and counted toward the credit for this item.

Clinical Supervision is defined as the provision of guidance, feedback, and training to team members to assure that quality services are provided to clients (e.g., following EBPs, negotiating ethical quandaries, managing transference and counter transference) and maintaining and facilitating the supervisee's competence and capability to best serve clients in an effective manner. Examples include the following:

- Meeting as a group (separately from the daily team meeting) or individually to discuss specific clinical cases;
- Field mentoring (e.g., helping staff by going out in the field with them to teach, role model skills, and providing feedback on skills);
- Reviewing and giving feedback on the specific tools (e.g., the quality of assessments, treatment plans, progress notes) to better capture and document clinical content;
- Didactic teaching and/or training;
- Formal in-office individual supervision (includes both impromptu meetings at least 20 minutes in length as well as scheduled); and
- A daily team meeting; however, if this is the only mechanism for supervision, rate at no higher than a "3" for this item and only credit for a daily team meeting if evaluators observe appreciable evidence of the team leader providing clinical supervision during the meeting.

Exclusion Criteria

Supervision needs are expected to vary across staff given experience and training; however, the fidelity evaluator should not count the following toward supervision:

- Brief, informal, unscheduled consultations (e.g., "Can I quickly touch base with you about a situation?" or "Hey, I need a minute of your time."). Although these are invaluable, they are difficult to reliably measure and we expect, at a minimum, this is occurring anyway. This item is focused on assessing more formal supervision offered by the team leader; whether scheduled or impromptu, it should be substantive.
- Estimations of weekly "drop-in" supervision.

Table 9. Categorization of Team Leader Services: Clinical Supervision and Direct Service Frequency

	Direct Clinical Services (see definition)	**Clinical Supervision (see definition)**
High level	At least 8 hours a week	Group and/or individual supervision provided every week to the two staff who consistently receive the most supervision.
Moderate level	4.0 – 7.9 hours per week	Group and/or individual supervision provided every two to three weeks to the two staff who consistently receive the most supervision.
Low level	0.5 – 3.9 hours per week	Group and/or individual supervision are provided, but less frequently than every three weeks to the two staff who consistently receive the most supervision.

	1	**2**	**3**	**4**	**5**
CT2. Team Leader as Practicing Clinician	Neither direct clinical services nor clinical supervision is provided at a frequency meeting low level standard.	A low level of frequency for both direct clinical services and clinical supervision OR one practice is not provided.	Both practices are provided at a moderate level of frequency OR one practice is provided at a high or moderate level, and one at a low level of frequency.	One practice is provided at a moderate level, and one practice is at a high level of frequency.	A high level of frequency for both direct clinical services and clinical supervision.

CT3. Psychiatric Care Provider on Team

Definition: The team has at least 0.80 FTE psychiatric care provider time to directly work with a 100-client team. Minimal qualifications include the following:

(1) Licensed by state law to prescribe medications; and
(2) Board certified or eligible (i.e., completed psychiatric residency) in psychiatry/mental health by a national certifying body recognized and approved by the state licensing entity. For physician extenders, must have received at least one year of supervised training (pre- or post-degree) in working with people with serious mental illness.

Rationale: Each team needs enough psychiatric care provider time to fulfill all required functions within the team (see CT4 and CT5). For 100-client teams, this requires a minimum of 32 hours per week. For 50-client teams, this requires a minimum of 16 hours per week.

DATA SOURCES (*denotes primary data sources)

Team Survey*

Review the team's response to item #1 to guide the questions below. Note whether the team has more than one psychiatric care provider, the FTE devoted by each, and the qualifications of each psychiatric care provider (i.e., do they have a psychiatrist, a physician extender, or both?).

Team Leader Interview*

I see based on your response to the Team Survey that you have ____ hours of psychiatric care provider time. Does the [psychiatric care provider] ever see clients who are NOT on the ACT team? *[If yes:] Is that included in this FTE estimate? What is the actual schedule of the psychiatric care provider?* [Determine if hours are relatively stable from week to week, or changes significantly week to week. If very long or weekend shifts are reported, explore how that time is being spent.] If there is <u>more than one</u> psychiatric care provider on the team: ***Does each*** *[psychiatric care provider]* ***work with their own caseload or do they typically share responsibility for seeing the same clients?*** [Check on how assignments are made, which should also be reflected on column C of Excel spreadsheet.] ***How do the psychiatric care providers know what is happening with each client psychiatrically since they share the role?*** *What is their communication process (i.e., format, quality, frequency)?*	

If the psychiatric care provider is a nurse practitioner or physician assistant: ***Approximately what percent of the*** *(nurse practitioner's or physician assistant's)* ***time is devoted to providing more traditional nursing services?*** *[If applicable:] Is that percentage included in the FTE estimate in the survey?*	
Psychiatric Care Provider Interview	
Can you describe a typical schedule working with this team in a given week? [See if hours and schedule corroborate with the level of time commitment and integration to the team itself (e.g., they are scheduled for blocks of time with the team throughout the week) as well as what is reported in Team Survey.] [Refer to Team Survey Item #1 reported qualifications and experience.] ***I see here you have approximately*** *(insert number of years)* ***experience working with people with serious mental illness. In what settings have you worked prior to working on this team?*** [If psychiatrist] ***Are you currently board certified in psychiatry?*** [If no] ***Where did you complete your psychiatric residency?*** [If a physician extender] ***Can you describe the supervision and training you received in working with people with psychiatric diagnoses?***	
ITEM RESPONSE CODING	
Rating Guidelines	
• Do not count if they are technically employed by the team but have been on extended leave for three months or more. • For teams with more than one psychiatric care provider, each provider must have at least 0.20 FTE (i.e., at least 8 hours per week) of clinical time to be considered part of the team (e.g., do not count reports of significant distant administrative support time, such as 8 hours off-site reviewing assessments and plans). If this standard is not met, do not count them toward the FTE calculation. Psychiatric residents do not yet meet qualifications and will not count toward the FTE in this item, but if they are at least 8 hours per week with the team, they may be counted as part of the team (e.g., in FTE for Program Size, and contacts for Intensity and Frequency of Services). • The expectation is that the psychiatric care provider has designated time with the team throughout the week, and those designated times include clinical work, interactions with the team, and other on-site administrative duties (it does not include days exclusively scheduled for "administration and paperwork," for example).	

- If the psychiatric care provider sees clients across agency programs throughout the day and week (e.g., appointments with ACT clients are commonly intermixed with appointments with other clients), attempt to adjust actual FTE to reflect time dedicated to ACT only.
- If the provider is a nurse practitioner: Allow for 20% of nurse practitioner FTE toward more traditional nursing responsibilities (e.g., intramuscular (IM) shots, medication management). If it is more than 20% and due to compensating for nursing practice rather than prioritizing integrated healthcare as a team, then deduct the FTE percentage accordingly. Similar criteria may be applied to Physician Assistants.
- Adequate communication standard when there are multiple providers: Teams with multiple providers (each at least 8 hours with the team) must demonstrate that there is adequate communication and collaboration between/among providers (i.e., there is a reliable process for sharing client information, consulting with one another about specific client needs and concerns, etc.) in order to aggregate the combined FTE. Sufficient communication between/among providers is particularly critical if sharing responsibility for treating the same caseload (rather than splitting the caseload). Poor communication between psychiatric care providers can also result in a resource drain on the team, who is then responsible for repeating information across providers. Teams who have multiple minimal part-time (8 - 12 hours/week) psychiatric providers are less likely to meet this adequate communication standard, and are also less likely to rate as well on CT4 and CT5 given more fragmented performance and less overall team integration.

Note: The denominator in this item is based on the number of clients currently served (not the number intended to serve when the team is at full capacity). If information across sources is inconsistent, the evaluator should ask for clarification during the team leader interview or make follow-up contact with the program. Similar to all scale items, the rating should be based on the most credible evidence available to the evaluator (e.g., even if the psychiatric care provider is reported as 0.80 FTE to a 100-person ACT team, if the clients and clinicians consistently report that they are unavailable for consultation, or the actual work time is questionably at the reported FTE level, an adjusted FTE and lower score may be appropriate).

Formula

$$\frac{\text{FTE value} \times 100}{\text{\# of clients currently served}} = \text{FTE per 100 clients}$$

Please refer to the TMACT Calculation Workbook to enter and compute these data.

Examples

West has 0.15 FTE of psychiatric care provider time for a 48-client program. South has 0.50 FTE for a 104-client program. Both meet qualifications.

WEST: [(.15 * 100) / 48] = 0.31 FTE psychiatric care provider → item coded as a "2"
SOUTH: [(.50 * 100) /104] = 0.48 FTE psychiatric care provider → item coded as a "3"

	1	2	3	4	5
CT3. Psychiatric Care Provider on Team	Less than 0.20 FTE psychiatric care provider(s) per 100 clients.	0.20- 0.39 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients OR criteria for a "3" rating met, except communication standard if two or more providers, OR at least 0.20 FTE with inadequate qualifications cited.	0.40- 0.59 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients with demonstrated communication and collaboration if two providers. OR criteria for a "4" rating met, except communication standard if two or more providers.	0.60- 0.79 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients with demonstrated communication and collaboration if multiple providers. OR criteria for a "5" rating met, except communication standard if two or more providers.	At least 0.80 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients. Two or more providers must demonstrate a mechanism for adequate communication & collaboration between/among providers.

CT4. Role of Psychiatric Care Provider in Treatment

Definition: In addition to providing psychopharmacologic treatment, the psychiatric care provider performs the following functions in treatment:

(1) *Typically* provides at least monthly assessment and treatment of clients' symptoms and response to the medications, including side effects;
(2) Provides brief therapy;
(3) Provides diagnostic and medication education to clients, with medication decisions based in a shared decision-making paradigm;
(4) Monitors clients' non-psychiatric medical conditions and non-psychiatric medications;
(5) If clients are hospitalized, communicates directly with clients' inpatient psychiatric care provider to ensure continuity of care; and
(6) Conducts home and community visits.

Rationale: The psychiatric care provider serves as medical director for the team, taking the lead in all psychiatric treatment and monitoring all other health conditions and medications.

DATA SOURCES (*denotes primary data source)

Excel spreadsheet (columns V and W)

Refer to team's practices around medications, especially the use of antipsychotic injections.

Chart Review (Log I)

Look at the extent to which the psychiatric care provider is delivering integrated healthcare and brief therapy. Of consideration, it is unlikely that brief contacts (e.g., 10 – 15 minutes) affords much time to provide integrated healthcare and brief therapy. Also examine frequency of visits.

Psychiatric Care Provider Interview*

We'd like to ask you some questions about your direct work with clients. Although no day may be truly typical, can you describe a typical day for you as it relates to the services you're providing to ACT clients? [Prompt with questions below depending on how much information they provide with this initial question. Ask of each provider, if there are two or more.] ***How often do you typically see clients? Who determines your schedule?*** ***Can you provide (additional) examples** of **brief therapy that you are providing**?* [Seek specific examples and try to understand how often brief therapy is provided and what does it tend to look like, what therapeutic techniques are being used]	

How do you talk with clients about the medications you are prescribing to them? Describe how they have a say in what you prescribe or how it is administered? [Prompt for whether they provide any education and the extent to which they work from a shared decision-making approach. Also inquire as to how decisions around antipsychotic injections are made. Inquire as to whether anyone is currently refusing all medications, and how the psychiatric care provider is addressing this choice. Also ask if the psychiatric care provider is prescribing Clozaril to anyone, and to how many.] ***Do you use a lab or monitoring service to assess medication adherence or substance use—where blood, urine, or saliva is sampled and sent to a laboratory?*** [If yes] *Describe how it is determined who such services are used with and implications for treatment.* ***Can you tell us more about your role regarding clients' non-psychiatric medical conditions and non-psychiatric medications?*** [Prompt for the extent to which they actively monitor non-psychiatric medical conditions and medications, and if there are any circumstances where they more directly treat. Also prompt for more preventive measures taken around wellness management. Refer to specific clients in the Excel spreadsheet, asking more specifically how the psychiatric care provider is delivering care to those with specific health conditions indicated.] ***If you haven't yet shared, can you provide a good example of your direct involvement in the assessment and/or treatment of a client's non-psychiatric condition?***	

Can you tell us (more) about your role when clients are hospitalized for psychiatric reasons? [Prompt for how actively psychiatric care providers are involved in coordinating care with inpatient staff—are they ever the first point of contact and when, do they ever visit a person in the hospital in person, and what is a recent example.] ***Where do you typically see clients?*** [Prompt for whether they typically see clients in the community on their own, or in the company of other team members—and reasons for this.] ***About what percentage of your time is spent in the office vs. in the community?***	

Nurse Interview*	
What is the psychiatric care provider's role in providing treatment? Describe the range of services they provide. [Prompt for each of the role areas described in the definition, specifically, prompt for their interpersonal style and use of shared decision-making, attention to broader health concerns, and communication with other providers.] ***How would you describe their approach in discussing medications with clients, particularly if the client is not wanting to take certain medications?*** ***In what ways does the psychiatric care provider work or communicate with inpatient psychiatric staff when clients are hospitalized?*** [Prompt for whether they are proactive, rather than relying more on nurses and other team members to coordinate care. If there are two or more providers, assess the role areas for each.]	

Clinician Interview	
What is your sense of the psychiatric care provider's role in providing treatment? Aside from prescribing medications, what other services are they providing? [Query for both providers separately if there are two; specifically, prompt for their interpersonal style with clients and use of shared decision-making, attention to broader health concerns, and communication with other providers.] ***How often do you see them getting out of the office to see clients? Are they willing to see clients independently, or do they prefer that another team member accompany them on visits?*** [If psychiatric care provider has someone accompany him or her into the field, try to understand the rationale for this.]	
Client Interview	
Do you meet with *(name psychiatric care provider)?* ***Please tell me how they help you. What do you like about working with them?*** [If there are more than one provider sharing responsibility in seeing everyone, inquire how well that is working for the client] ***Is there anything you'd like to be different in how you work with (name) and the services you receive?***	

ITEM RESPONSE CODING
Rating Guidelines
If <u>two or more</u> psychiatric care providers share this role <u>at different FTEs</u>: Base this rating on the extent to which the psychiatric care provider with the highest FTE meets the six treatment functions. **If <u>two or more</u> psychiatric care providers share this role <u>at equal FTEs</u>**, assess based on whether their caseload is split or shared: **If the caseload is <u>split</u>:** Base this rating on the psychiatric care provider who fulfills the <u>fewest</u> number of functions within the team. For example, if one provider performs all six treatment functions, but the second provider only fulfills functions #1 through #3, then the highest rating they can achieve is a "2" based on the second provider's performance. **If the caseload is <u>shared</u>:** Base this rating on a collective appraisal of providers' performances. Please use Table 10 to assist with rating each function and making your overall rating.

Table 10. Role of Psychiatric Care Provider in Treatment			
Functions	**No Credit**	**Partial Credit**	**Full Credit**
Function #1: Typically provides at least monthly assessment and treatment of clients' symptoms and response to the medications, including side effects.[5]	Less than 40% of clients are seen by a psychiatric care provider approximately monthly (i.e., every 1 – 6 weeks) AND/OR Clients are seen less frequently than every three months <u>without a good rationale.</u>	About 40-64% of clients are seen by a psychiatric care provider approximately monthly (i.e., every one to six weeks); OR At least 65% seen approximately monthly, but several clients are seen less frequently than every three months <u>with good rationale</u> (e.g., less frequent follow-up is part of a transition plan; attempted contacts are documented).	At least 65% of clients are seen by a psychiatric care provider approximately monthly (i.e., every one to six weeks), AND No clients are seen less frequently than every three months (an exception or two with good rationale may be permissible). <u>Note</u>: Frequency of service provision should be titrated depending on client need and treatment plan specifications. Although it may not be feasible to provide such frequent assessment to institutionalized clients, the provider does make an effort to have face-to-face and collateral contact to assess status.
Function #2: Provides brief therapy.	Does not, or very rarely provides brief therapy. No examples were provided reflecting the use of empirically-supported	Some brief therapy appears to be provided, but limited in number of clients receiving and/or more limited presence across data sources (e.g., reports of such are provided, but see no evidence in chart review).	Brief therapy is provided and follows principles in alignment with known empirically-supported therapies (e.g., motivational interviewing (MI), CBT). Examples include the following: • Clarification of clients' beliefs and feelings about their symptoms, mental illness, medication, and issues of "chemical control" • Cognitive restructuring • Problem-solving • Role-playing

[5] Use the Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of clients seen at least every six weeks and no less frequently than every three months.

Table 10. Role of Psychiatric Care Provider in Treatment			
Functions	**No Credit**	**Partial Credit**	**Full Credit**
	therapies within contacts, or examples were extremely limited in quality or quantity.		• Examining pros and cons • Relaxation training • Activity and pleasant event scheduling Evidence of brief therapy should be present across multiple client contacts and data sources, such as interviews and chart reviews.
Function #3: Provides diagnostic and medication education to clients, with medication decisions based in a shared decision-making paradigm.	Does not provide diagnostic or medication education to clients; shared decision-making model is not used.	Provides diagnostic and medication education to clients, but there is some report by clients or other team members that it is inconsistently provided, that it is provided using medical jargon, and/or there are notable instances where a shared decision-making model is not used.	Psychiatric care provider provides information to the client about their psychiatric diagnosis and answers any questions or concerns that arise about that diagnosis and related symptoms/behaviors. Psychiatric care provider meets with each client to discuss the medications they are prescribing, where this discussion may include: • Anticipated benefits; • Possible side effects; • **Clients' past experiences, values, and preferences;** • Administration details, and • Areas of needed collaboration in taking the medication. A variety of medications and administration modes (orals vs. IM injections) corroborates report of a shared decision-making approach. The psychiatric provider uses non-judgmental and non-medical language that is understandable to the client and engages in shared decision-making whenever possible. Psychiatric care providers who typically have short, infrequent visits are often less likely or able to use a shared decision-making model.
Function #4: Monitors clients' non-psychiatric medical conditions and non-psychiatric medications.	Although the provider may be aware of non-psychiatric medical conditions and medications, there is no monitoring.	Monitors non-psychiatric medical conditions and medications, but there is evidence of inconsistent work in this area (e.g., screening and monitoring, but not coordinating with primary care providers).	The psychiatric care provider, in collaboration with nursing, oversees the overall medical care of clients on the team, including: • Regular screening for medical conditions (e.g., ordering lab work, requesting that nurses conduct screening for metabolic syndrome for clients taking atypical antipsychotics); • Consistent monitoring of existing medical conditions (monitoring blood-glucose levels for those with diabetes); • Assessing wellness/health management skills and collaboratively working with the team on developing a wellness management plan or strategy (nicotine replacement therapy; nutrition); and • Checking in with clients and coordinating with primary care/medical doctors regarding medical conditions that require treatment outside the ACT team, as well as non-psychiatric medications.

Table 10. Role of Psychiatric Care Provider in Treatment			
Functions	**No Credit**	**Partial Credit**	**Full Credit**
Function #5: If clients are hospitalized, communicates directly with clients' inpatient psychiatric care provider to ensure continuity of care.	Psychiatric care provider does not communicate with inpatient psychiatric care provider when clients are hospitalized.	There is some contact with inpatient providers when clients are hospitalized, but this does not occur on a regular basis, and/or provider relies heavily on nursing and other staff to communicate with inpatient staff.	When clients are hospitalized, the psychiatric care provider contacts the inpatient psychiatric provider and/or team to discuss the circumstances surrounding the client's hospitalization, medication and symptom history, most recent medications and response to those medications, and overall treatment planning to best support the client during inpatient hospitalization and promote a healthy return to the community. Recent examples (past six months) are provided where the psychiatric care provider has visited a client in the hospital.
Function #6: Conducts home and community visits.	Does not conduct home and community visits, or community contacts are dictated by efficiency rather than clinical need. E.g., provider goes into the community to a residential setting to see ACT clients who reside at that one residence, but does not see other ACT clients in the community.	Psychiatric care providers on new teams spend less than 50% of their time in the community, but do get out of the office for many contacts, per clients' clinical needs. Providers on more established teams spend less than 30% of their time in the community, but do get out of the office for many contacts, per clients' clinical needs; AND/OR psychiatric care providers rely heavily on other staff to accompany him or her out in the community when seeing clients.	The value of community-based contacts may be balanced with efficiency of time. Psychiatric care providers of established teams are expected to have at least 30% of the client contacts in the community, and all or nearly all clients have been met in the community at least one time. Psychiatric care providers of newer teams (operating less than year) are encouraged to spend more time in the community (at least 50%) as there is more work to engage clients, and help serve to model community-based work to the team. It is expected that psychiatric care providers conduct outreach independently, not requiring the company of other staff members beyond practices common for all (e.g., doubling up for safety concerns for a particular client; providing field supervision).

	1	**2**	**3**	**4**	**5**
CT4. Role of Psychiatric Care Provider in Treatment	The psychiatric care provider performs 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (1 is absent) OR ALL 6 functions are performed, but more than 2 are PARTIALLY performed.	ALL 6 functions are performed, but up to 2 functions are only PARTIALLY performed.	ALL 6 treatment functions FULLY performed.

CT5. Role of Psychiatric Care Provider within Team

Definition: The psychiatric care provider performs the following functions within the team:

(1) Collaborates with the team leader in sharing overall clinical responsibility for monitoring client treatment and team member service delivery;
(2) Educates non-medical staff on psychiatric and non-psychiatric medications, their side effects, and health-related conditions;
(3) Attends the majority of treatment planning meetings;
(4) Attends daily team meetings in proportion to the minimum time expected for caseload size;
(5) Actively collaborates with nurses; and
(6) Provides psychiatric back-up to the program after-hours and weekends (Note: may be on a rotating basis as long as other psychiatric care providers who share on-call have access to clients' current status and medical records/current medications).

Rationale: In addition to being the medical director of the team, the psychiatric care provider is a fully integrated member of the team, actively collaborating and communicating with other team members and regularly attending all necessary meetings to guide treatment.

DATA SOURCES: (* denotes primary data sources)

Team Leader Interview*

Aside from the clinical services they provide, what is the psychiatric care provider's role within the team? For example, how much do they participate in daily team meetings or treatment planning meetings? [If there are two or more psychiatric care providers, prompt for specific roles identified above for each provider.]	
Can you describe your professional relationship with the psychiatric care provider? How do your roles compliment and/or conflict with one another? [Prompt for how they share team clinical leadership and oversight responsibilities. If there are two or more providers, prompt for specific roles for each.]	

Psychiatric Care Provider Interview*	
Now we'd like to ask you questions as relates to other ACT team staff. How do you see your role within the team—as a team member, separate from the services you provide? [Depending on their response, you may want to ask some of the specific questions listed below. Ask this of each provider if there are two or more.]	
Can you describe your work and relationship with the team leader? *Is it a collaborative relationship? Are there conflicts?* [If more than one psychiatric care provider, further query for how psychiatric care providers work together with team leader.]	
Can you give (additional) examples for how you provide information to other team members regarding medications or clients' health conditions?	
How often do you attend any treatment planning meetings? [A treatment planning meeting is where staff come together with a client to review goals, progress, and develop/update the plan itself. This is different than a clinical treatment team meeting where team members, with or without client and other stakeholders, do some needed problem-solving.] ***For which clients do you attend planning meetings, and how often are such meetings held?***	
How often do you attend daily team meetings? How long do you stay?	

In what ways do you work together with the nurses on the team? Do you have any set aside meeting time with the nurses? [If yes] *What are those meetings focused on?* ***Who provides psychiatric back-up to the team during weekends and after-hours?*** [If there is more than one psychiatric care provider:] ***How do you ensure that clinical information is communicated between you and the other psychiatric care provider(s) on the team?*** ***Is there any part of your role that you find to be challenging to fulfill or carry out day-to-day?*** [Prompt for details] ***Are there areas of education or training you think would be helpful for you to do an even better job delivering ACT services?***	
Clinician Interview	
Who would you say provides clinical leadership to the team? ***How do the team leader and psychiatric provider(s) work together in sharing their leadership responsibilities within the team?*** *What are their respective roles? Are they complementary? Conflicting?* [Ask the following regarding all providers if there are two or more.] ***How often does the psychiatric care provider attend your daily team meeting?***	

How often do they attend treatment planning meetings, especially ones where the client is present and the focus is on plan development? ***Can you provide examples in how they talk with you about clients' medications and related medication needs? How often does this occur?*** ***Are they readily accessible****? What is the typical approach to getting in touch with the psychiatric care provider when they are needed? Are they ever on-call for emergencies with clients?*	

ITEM RESPONSE CODING

Rating Guidelines

Use the team leader and psychiatric care provider interviews as primary data source. Use data from clinician interviews to back-up conclusions. If the psychiatric provider fulfills all six functions within the team, rate this item as a "5."

Treatment Planning Meeting Attendance: To receive credit, an ACT psychiatric care provider must be attending the planning meetings for at least 50% of the caseload if planning meetings are held at least every six months; and/or attend all client planning meetings if held annually. No credit if such planning meetings are not held at least annually.

If two or more psychiatric care providers share this role: Rate this item from the perspective of the team in terms of whether they have adequate access to each of these functions, thereby strengthening the team, given the commitment and role of the collective body of psychiatric care providers. If one provider is clearly stronger than another in a particular function, and this appears to have a negative consequence for the team (e.g., the former provider is at a lesser FTE), then do not give credit for that function. Note that credit for daily team meeting attendance should consider the expected minimal coverage given the size of the team. Two examples: (1) A team serving 100 clients should have access to at least 32 hours of psychiatry and attendance of psychiatric care provider staff at a minimum of four days per week. If a team this size, however, had a psychiatrist at 16 hours and attending two days a week, they would not meet this standard (of four daily team meetings given the size of the team). (2) A team with two psychiatric care providers at an aggregate 32 hours of psychiatry time (0.80 FTE) should have psychiatric care provider attendance for at least four daily team meetings per week, regardless if they share in this responsibility equally (e.g., both attends two meetings per week) or not (e.g., one attends once a week, and the other three times per week).

CT5. Role of Psychiatric Care Provider within Team	**1**	**2**	**3**	**4**	**5**
	The psychiatric care provider performs no more than 2 team functions total.	3 team functions are performed.	4 team functions are performed.	5 team functions are performed.	ALL 6 team functions are performed.

CT6. Nurses on Team

Definition: The team has at least 2.85 FTE registered nurses (RNs) assigned to work within a 100-client team. At least one full-time RN on the team has a minimum of one year of experience working with adults with severe mental illness. NOTE: This item is rated based on 2.85 FTE (vs. 3.0 FTE) since there is more likelihood for the team to get penalized on this item if the census goes even slightly above the 100-client team.

Rationale: Nurses have been found to be a critical ingredient in successful ACT programs. According to research studies, the presence of a nurse on an ACT team is associated with improved client outcomes.

DATA SOURCES: (* denotes primary data source)

Team Survey*

Please refer to the item #1 response by noting FTEs and qualifications.

Nursing Interview*

Review and confirm hours with team, degree, and qualifications. ***Approximately what percent of your workweek involves nursing-related activities as opposed to being called upon to engage in activities that clearly do not include a nursing function?*** (Use this estimate to gauge the extent to which they are functioning within the critical roles -- e.g., if they endorse activities representing all six critical roles, but then report that only 40% of their time is engaged in nursing activities, then follow-up questions and referencing other data sources is key to determining true nature of their role within team). ***Are you assigned as the "primary" team member or care coordinator for any clients, or serve on ITTs? If so, how many and why do you think you were assigned to work with those particular clients (i.e., did they have more specialized health-related needs the nurses were best equipped to address)?*** [This additional information provides context for how the nurses may be employed within the team.]	

ITEM RESPONSE CODING
Rating Guidelines
• Inquire about whether nurses have responsibilities outside of the ACT team and adjust FTE time accordingly. • A nurse practitioner serving as the team psychiatric care provider does not count toward the nursing FTE total unless the break-out of time is clear and supported by multiple data sources. • 1.0 FTE licensed professional nurse (LPN) or certified medical assistant (CMA) may count toward FTE total, but at 75% of the FTE time and only if team has at least 1.0 FTE RN also on team (0.5 LPN or CMA may count toward FTE total, but at 0.38 of the FTE time). For example, if a 100-client team has 2.0 FTE RNs and 1.0 FTE LPN, then the team is rated based on 2.75 FTE nursing time, which results in a rating of "4"). • Refer to OS1 staffing inclusion criteria. Do not count as part of the team if actual time dedicated to ACT is less than 16 hours per week and/or the nurse does not attend at least two daily team meetings per week. Do not count both FTE of permanent staff on leave and interim temp staff. **Note:** The denominator in this item is based on the number of clients currently served. If inconsistent, then the assessor should reconcile information across sources and score accordingly.
Formula
Prorate FTE per 100 clients: ___total FTE value x 100___ # of clients currently served = FTE per 100 clients Please refer to the TMACT Calculation Workbook to enter and compute these data.

	1	2	3	4	5
CT6. Nurses on Team	Less than 0.50 FTE RNs per 100 clients.	0.50 – 1.40 FTE RNs per 100 clients.	1.41 – 2.10 FTE RNs per 100 clients OR Criteria for "4" or "5" rating met, however no full-time RNs have a minimum of 1 year experience working with adults with severe mental illness.	2.11 - 2.84 FTE RNs per 100 clients.	At least 2.85 FTE Registered Nurses (RNs) per 100-client team; at least 1 full-time nurse must have at least 1 year experience working with adults with SMI. If not, rate no higher than a "3".

CT7. Role of Nurses

Definition: The team nurses perform the following critical roles (in collaboration with the psychiatric care provider):

(1) Manage the medication system, administer and document medication treatment;
(2) Screen and monitor clients for medical problems/side effects;
(3) Communicate and coordinate services with the other medical providers;
(4) Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change);
(5) Educate other team members to help them monitor psychiatric symptoms and medication side effects; and
(6) When clients are in agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).

Rationale: As described previously, nurses have been found to be a critical ingredient in successful ACT programs. The reason for this is that they play a key role in both direct service and staff education, broadly defined to include not only medication management, but also screening for health problems, health promotion and education, coordination of services with health providers, and cross-training to other ACT staff.

DATA SOURCES (* Denotes primary data source)

Excel spreadsheet (column N, V and W)

Refer to team report on health/lifestyle interventions provided (column N): _____

Refer to team's practices around oral medication management and monitoring (column V) _____ and IM injections (column W): _____

Chart Review (Log I)

Review charts for the extent to which team is providing health/lifestyle interventions.

Team Leader Interview*

What role do the nurses play on the ACT team? [Prompt for roles above.] ***Do the nurses ever have responsibilities (or serve clients) outside the ACT team?***	

Psychiatric Care Provider Interview	
Please describe how the nurses manage the medication system for ACT clients. [Prompt for the quality of work, such as timely refills, accuracy in preparing medication packets for distribution, and accuracy in maintaining medication administration records (MAR) and updated lists of prescribed medications.]	
Nurse Interview*	
Describe your role on the ACT team. What does your day-to-day work look like? [Follow-up with specific questions below, depending on whether they provide enough information regarding the six roles listed above. Use reflections and summaries to verify what you have so far heard in this opening question as it relates to below topics.] ***Can you tell us more about your specific role within the team regarding medications****?* [Refer to column V on Excel spreadsheet—how many oral medications are directly managed by the ACT team and ACT nursing staff? Gather information on medication check-in, storage, and delivery to clients, including the rates at which clients have medications delivered by team.] [For next several questions, refer to Full Credit column in Table 11 on pp. 61-63 to help determine the extent to which nurses are fulfilling these functions.] ***Can you tell us more about what you do regarding clients' health conditions****? How are lab work and basic health status indicators (e.g., blood pressure, weight, blood-glucose levels) monitored for non-psychiatric conditions? Are these health data tracked in any way? What kind of nursing assessments do you use* [Prompt for abnormal involuntary movement scale (AIMS) assessment]*? How often do you conduct them?*	

In what ways do you help with communication between the team and non-ACT healthcare providers as it relates to client care? [Prompt for whether communication sheets are used, the reliability of this exchange, and how this information is maintained within the team. Ask for a copy of a health communication form.] ***Do you accompany participants to healthcare appointments? How do you decide who accompanies them?*** [Seek examples] ***Please tell us more about any work you do on prevention or health promotion with clients.*** *Tell us about the health and lifestyle interventions you are using with clients.* [Refer to column N on Excel spreadsheet and Full Credit column under Function #4.] ***What is your role regarding training other team members on clients' medications and/or their health conditions?*** [Prompt for examples as needed—is this more informal 1:1 or in daily team meeting, is it with any prepared and shared educational materials?] ***Please describe any specific strategies you use to help people take their medications as prescribed on their own*** [If needed, prompt for examples of individuals who are not opposed to taking medications, but do not do so consistently due to confusion, memory, or cognitive or behavioral impairments.]	

Is there any part of your role that you find to be challenging to fulfill or carry out day-to-day? [Prompt for details] ***What are the areas of education or training you think would be helpful for you to do an even better job in your role?***	
Clinician Interview	
Do the nurses on the team ever talk with you about how to monitor psychiatric symptoms, medication side effects, or other health-related issues? [Ask for specific examples, and **gauge frequency** with which this occurs]	
ITEM RESPONSE CODING	
Rating Guidelines	
Use Table 11 to determine full and partial credit for each function to determine your overall rating. Use the nurse and team leader interviews as primary data sources; use chart reviews to back-up conclusions. If the nurses fulfill all six functions within the team, rate this item as a "5."	

Table 11. Role of Nurses

Function	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Manage the medication system, administer and document medication treatment	Nurses do not or rarely manage the medication system, administer and document medication treatment. Greater than 66% of clients are independently managing medications on their own (e.g., picking up and storing monthly medications at their home) and/or receive these medications directly from residential staff.	Nurses are inconsistent in fulfillment of this particular role. Anywhere from 34% - 66% of clients are independently managing medications on their own (e.g., picking up and storing monthly medications at their home) and/or receive these medications directly from residential staff.	Nurses take the lead on filling prescription orders, storing and putting together medication deliveries and packets, managing IM injection schedules and administering injections, and ensuring that the MAR and all other documentation related to medications is accurate and up-to-date. One-third (33%) or less of the caseload should be independently managing medications on their own (e.g., picking up and storing monthly medications at their home) and/or receive these medications directly from residential staff. Although ACT helps individuals have more independence and responsibility with medications, there are many reasons why a priority clinical population for ACT benefits from medications routed through the team, including: being positioned to modify and tailor medication supports as needs change; assessing and detecting medication errors and changes; and being able to prescribe and monitor controlled substances.

Table 11. Role of Nurses			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #2: Screen and monitor clients for medical problems/side effects	Nurses do not or rarely screen and/or monitor clients for medical problems/side effects.	Nurses screen and monitor clients for medical problems and side effects, but there is indication that this is less consistently conducted or the quality is variable (e.g., not using available standardized assessments).	Nurses conduct regular screening for medical conditions and side effects of medications and monitor existing or newly-identified medical conditions as clinically indicated and/or as physical health status changes, and at least annually. Examples of screening and monitoring for medication side effects include: • Completion of the AIMS to assess and monitor tardive dyskinesia; • Measuring waist circumference and blood pressure, and completing/ordering lab work on triglycerides, HDL cholesterol, and fasting glucose to assess for metabolic syndrome secondary to certain second generation antipsychotic medications; Examples of screening and ongoing monitoring for medical conditions include: • Ensuring all immunizations and medical exams are up-to-date; • Assessing health/medical risk factors or conditions (e.g., assessing for obesity, diabetes, hypertension, high cholesterol) and associated wellness management skills; • Tracking all age-related and family history health screens (e.g., a colonoscopy at age 50, prostate exam for men at age 50 or earlier if African-American or a family history; a mammogram for women at age 40).
Function #3: Communicate and coordinate services with the other medical providers	Nurses do not or rarely communicate and coordinate services with the other medical providers.	Nurses contact inpatient and outpatient medical and psychiatric care providers who are treating ACT clients, but there is evidence that this is less consistently done or that this communication is often difficult (e.g., difficulty with inpatient providers calling them back or following-up on the ACT team's recommendations for medication changes). Health communication forms may be used, but not reliably.	Nurses assume a lead role (ideally, in collaboration with psychiatric care provider, see CT4) in coordinating care with other medical providers, including primary care, specialists, and dentists. Evidence that all or most of these functions are fulfilled: • Regularly contact inpatient and outpatient medical and psychiatric care providers who are treating ACT clients, which may occur when a client is hospitalized or when they have an outpatient medical appointment; • Accompany clients to appointments; • Use health communication forms to relay and receive information from non-ACT health providers.
Function #4: Engage in health promotion, prevention, and education activities	Nurses do not or rarely engage in health promotion, prevention, and/or education activities.	Nurses provide some health promotion, prevention, and/or education activities, but do so inconsistently or their scope is limited.	Per interview and chart data, nurses consistently engage in health promotion, prevention and education activities, such as the following: • Working on behavior change strategies related to identified health risk behaviors (e.g., education regarding the importance of safe sex practices, provision of condoms);

Table 11. Role of Nurses			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
			• Intervening on health/medical risk factors or conditions (e.g., providing education and teaching self-management skills to clients with diabetes, obesity, hypertension, high cholesterol); Engaging in strategies to reduce tobacco use (e.g., providing education about and/or access to nicotine replacement therapy, facilitation of smoking cessation counseling or groups like Learning About Healthy Living [LAHL]).
Function #5: Educate other team members to help them monitor psychiatric symptoms and medication side effects	Nurses do not or rarely provide education to other team members to help them monitor psychiatric symptoms and medication side effects, but do so inconsistently.	Nurses provide some education to other team members to help them monitor psychiatric symptoms and medication side effects, but do so inconsistently and/or passively.	Nurses provide regular education to other team members, either formally (e.g., cross-training) or informally (in the daily team meeting) to help them monitor psychiatric symptoms and medication side effects. Education efforts are intentionally inserted into work rather than reflect passive responses to team questions.
Function #6: When clients are in agreement, develop strategies to maximize the taking of medications as prescribed	Nurses do not or rarely develop strategies to maximize the taking of medications as prescribed.	Nurses play some role in assisting with improving medication adherence, but this role is limited in scope or inconsistently provided.	Nurses work with the psychiatric care provider and team to develop ways to improve medication adherence, such as the following: • Behavioral tailoring (e.g., tying med box to toothbrush as a reminder to take medications, putting medications near coffee pot); • Using cues and reminders (post-it notes, prompts from the team, setting up a cell phone or computer reminder), and pill organizers; and • Simplifying or moving dosing, such as reducing to a one time a day medication, considering IM injection because it is preferred by the client.

	1	**2**	**3**	**4**	**5**
CT7. Role of Nurses	Nurses perform 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (1 is absent) OR ALL 6 functions are performed, but more than 3 are PARTIALLY performed.	ALL 6 functions, with up to 3 functions are PARTIALLY performed.	ALL 6 functions are FULLY performed.

ST1. Co-Occurring Disorders (COD) Specialist on Team

Definition: The team has at least one 1.0 FTE team member designated as a co-occurring disorders (COD) specialist who has at least a bachelor's degree and meets local standards for certification as a co-occurring specialist. Preferably this specialist has training or experience in integrated treatment for COD.

Rationale: Co-occurring disorders are common in persons with severe mental illness. Appropriate assessment and intervention strategies delivered by competent staff are critical. As a result, it is essential to include a dedicated position to lead these strategies.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to item #1, noting FTE and qualifications.

Excel spreadsheet (column B)

How many clients are reported to be receiving integrated treatment for COD directly from the ACT team? _____

Chart Review

Cross-walk what specialists report as the percent of contacts that involve specialist services with what is observed in the review of progress note entries (e.g., what percent of progress note entries by COD specialist have some notation of integrated treatment for COD, inclusive of assessment and engagement?). Significant discrepancies may warrant an adjustment from what was reported and what was observed in the chart (e.g., specialist reports 90%, and chart review data finds only 50%; in such a case, given what other data sources indicate (e.g., scheduling practices), reducing to 70% may be a more accurate reflection of how the specialist is used in his or her role).

Co-Occurring Disorders Specialist Interview*

Please tell us about your training and experience in delivering integrated treatment for co-occurring disorders (COD).	
If you were to think of a typical week, approximately what percent of client contacts involve some type of integrated treatment for co-occurring disorders service, which include outreach and engagement?	
Are you assigned as the primary care provider or coordinator for any clients? If so, how many and, of those, who have a co-occurring substance use disorder? If your team uses ITTs, how many client's ITTs are you a part of? [This additional information provides context for how the specialist(s) may be employed within the team.]	

ITEM RESPONSE CODING

Inclusion Criteria

If two specialists are on the team: It is acceptable and encouraged to consider the cumulative percent of time devoted to specialty services for up to two individuals serving in this specialty role. Please see the note in the rating guidelines section regarding inclusion of team members who may not be formally designated as a specialist, but have assumed more specialty service responsibilities.

Exclusion Criteria

Refer to OS1 for general inclusion and exclusion criteria (e.g., at least 16 hours of week with team, attending at least two daily team meetings per week).

Rating Guidelines and Formula

Several criteria are considered when determining the rating for ST1. These criteria include the following:

1. Reported time in position (i.e., full-time equivalency (FTE));
2. Actual time devoted to specialty-related activities[1] while in the position; and
3. Qualifications of the specialist(s).

NOTE: Up to two team members may be considered in this rating. Even if the team formally has one team member designated as the COD specialist, evaluators are encouraged to prompt the team leader prior to the fidelity review to determine whether there is any other team member who assumes responsibility for delivering integrated treatment for COD (please see the fidelity review orientation letter in Appendix A). Even if this secondary "COD specialist" does not meet minimal qualifications, they may positively contribute to this rating, which is in the spirit of the team sharing responsibility for services. However, be sure to simultaneously deduct from other staff FTE item, as relevant (e.g., a full-time peer specialist cannot be both credited for serving in peer specialist role full-time (at least 80% of time representing peer functions) and also be credited for 50% time toward COD specialist role).

To rate ST1, input data obtained from pre-fidelity survey and interviews into Table 12.
Then use these data to complete Steps 1 – 3 below.

Table 12. Summary of Data Used to Rate COD Specialist on Team.		**COD Specialist**	
Criteria		**Primary Specialist**	**Secondary Specialist (if applicable)**
A	FTE with ACT team (see pre-fidelity survey and interview data; (FTE = # of hours employed with ACT per week / 40))		
B	Time devoted to specialty-related activities[1]: estimated % of client contacts that involve integrated treatment for COD service (based on interview responses, cross-checked with other data sources[2]).		
C	Meets minimal qualifications, which entails meeting local standards for certification or licensure as a COD specialist and has at least a bachelor's degree. (see under Step #3 below)		

Step 1. Determine Provisional Rating Given the Adjusted FTE (criteria A and B in Table 12)

***Please refer to the TMACT Calculation Workbook to enter and compute these data.

a. **If *80% or more* of client contacts involve specialist-related activities** (criterion B), per specialist report and other sources[2]), **give full credit for the reported FTE on the team** (criterion A). Refer to Table 13 to determine provisional rating (Note: it remains "provisional" because we have yet to examine impact of qualifications).

Example a: Specialist is 1.00 FTE (i.e., 40 hours/week) and reports that 90% of contacts involve COD specialty and other sources support that estimate, then 1.00 FTE (i.e., actual FTE) is used, which provisionally rates a "5" based on Table 13.

b. **If less than 80% of client contacts involve specialist-related activities** (criterion B), per specialist reports and/or other sources[2]), **calculate an adjusted FTE**, which is then used to determine the provisional rating based on Table 13.

Table 13. Provisional Ratings Following Step 1.

FTE	Rating
1.00 +	5
0.75 – 0.99	4
0.50 – 0.74	3
0.25 – 0.49	2
0.00 – 0.24	1

Calculating the Adjusted FTE =

Full-Time

- **If specialist is full-time with the team** (i.e., 1.0 for criterion A in Table 12)**:** Add 10 to the estimated percent of time dedicated to specialist role (criterion B in Table 12), and divide by 100.

Example b1: A full-time COD specialist reported, and other data sources corroborated, that 50% of her time was spent providing specialty services. Her adjusted FTE would be 50 + 10 = 60 / 100 = 0.60 Adjusted FTE, which provisionally rates a "3" based on Table 13. (Note: it remains "provisional" because we have yet to examine impact of qualifications)

Part-Time

- **If specialist is part-time with the team** (i.e., less than 1.0 FTE reported for criterion A in Table 12)**,** use the following formula to calculate the adjusted FTE:
((FTE on team, which is criterion A in Table 12) * (percent of client contacts involving specialty-related activities[1], which is criterion B in Table 12)) +.05.

Example b2: A COD specialist was employed with the team for 24 hours a week, or 0.60 FTE. She estimated that 50% of her time was spent providing specialty services. **(0.60** (which is FTE on team, or criterion A) **0.50** (representing 50%, or criterion B)**) + 0.05 = 0.35 Adjusted FTE**, which provisionally rates a "2" based on Table 13.

Step 2. Complete if there are two specialists; otherwise skip to Step 3

Aggregating FTE for Two Specialists: If there are two specialists in position, go through Step 1 above for each specialist and add together total adjusted FTE and determine provisional rating based on Table 13.

Example c: A team has a designated COD specialist who is full-time (1.0 FTE) with the team. He reported that at least 75% of his client contacts involve integrated treatment for co-occurring disorder services; the evaluators could not find data that supported such a high estimate (e.g., only 35% of his chart note entries reflected any specialty services) and agreed that 60% was more accurate.

A second team member was interviewed, as this person has a master's degree and has co-led integrated treatment for co-occurring disorder groups, as well as delivered some individual COD counseling. She works with the team four days a week at 0.80 FTE. She estimated that, of all the clients she meets with in a typical week, approximately 35% involve integrated treatment for COD intervention. The evaluators found other evidence to support that estimate.

COD specialist 1 (full-time): (**60** (reflecting the 60% estimated time in role) **+ 10** (formula instructions to add "10")) **/ 100 = 0.70 Adjusted FTE**.

COD specialist 2 (part-time): (0.80 (reflecting her FTE on the team) *** 0.35** (reflecting 35% time in specialty role)**) + 0.05** = **0.33 Adjusted FTE**

Aggregate Adjusted FTE = 0.70 + 0.33 = 1.03 Total Adjusted FTE (Provisional "5" rating based on Table 13 – recall, it remains "provisional" as we have yet to determine impact of qualifications standard)

Step 3. Qualifications Determination for Final Rating (Criteria C in Table 12).

a. One specialist on team (see Step 1 examples above):

- **Provisional rating becomes final rating if the following qualifications are met:** Meets local standards for certification or licensure as a COD specialist and has at least a bachelor's degree.
- **Provisional rating is *adjusted down* to next lowest rating if above minimal qualifications are not met** (i.e., If the specialist in example a did not meet minimal qualifications, her provisional rating of a "5" becomes a "4;" if specialist in example b1 above did not meet minimal qualifications, her provisional "3" rating is reduced to a "2" rating.).

b. Two specialists on team (see Step 2 examples above):

- **Two unqualified staff:** Provisional rating is adjusted down to next lowest rating if *both* specialists do not meet above minimal qualifications.
- **One qualified and one unqualified staff:** If one specialist meets qualifications, but the other does not, the final rating is the higher of the following two options: a) final rating is based solely on the one qualified staff or, b) final rating based on two unqualified staff (i.e., in example c described above, assume that Specialist 1 (adjusted FTE of 0.70) met qualifications, but Specialist 2 (adjusted FTE of 0.33 FTE) did not. Their aggregate FTE is 1.03 FTE (provisional "5" rating), and would be reduced to a "4" as one specialist does not meet qualifications (option b). Alternatively, we could rate based only on the one qualified staff, Specialist 1 (option a). However, her adjusted FTE of 0.70 only earns a "3" rating on its own. Thus, in this example, the option b should be used as the aggregate FTE of 1.03 that provisionally rates a "5," but then reduced one rating to a "4" results in the higher rating of the two options.

[1] **Specialist-related activities**: Estimated percent of client contacts that involve any activity associated with the specialty area. Qualifying client contacts include those where engagement practices are delivered while providing other case management services, as well as more obvious specialty-related interventions or assessments. To get full credit (i.e., to be rated according to actual FTE with the team), *at least 80%* of client contacts should involve a specialty-related activity.

[2] **Supporting specialists' estimations:** Evaluators are encouraged to consider other data sources to gauge the approximate amount of time spent in specialist activities. Evaluators should first consider the specialist's estimation, then cross-check that estimation with other data sources, such as activities reported in the daily team meeting, noted in the client log, and progress notes. If a significant discrepancy occurs, evaluators should adjust this percentage, discussing with specialist if possible to agree on a more accurate percentage of time devoted to specialist activities. Otherwise, evaluators should adjust reported percentage, keeping in mind the following heuristic guidelines:

- For a specialist who provides a *high degree* of integrated treatment for COD services (e.g., 80% or more), it is assumed that such a high level of practice will be evident across multiple data sources—e.g., chart review (majority of notes (at least 60%) written by this specialist indicates some integrated treatment for COD services,

inclusive of engagement and MI), observation of daily team meeting (i.e., reported contacts involving integrated treatment for COD services, and scheduled contacts to address integrated treatment for COD needs), and a relatively large breadth of integrated treatment for COD being provided.

- For a specialist who provides a *moderate degree* of integrated treatment for COD services (e.g., 40% - 60%), it is assumed that a moderate level of practice will be evident across several data sources—e.g., chart review (some notes (e.g., 20% - 60%) written by this specialist indicates integrated treatment for COD service, inclusive of engagement and MI), observation of daily team meeting (i.e., reported contacts involving integrated treatment for COD services, and scheduled contacts to address integrated treatment for COD needs), the breadth of integrated treatment for COD being provided may vary.
- For a specialist who provides a *low degree* of integrated treatment for COD services (e.g., 10% - 30%), it is assumed that there will be little evidence of such practice when reviewing multiple data sources—e.g., chart review (very few notes (< 20%) written by this specialist indicates some integrated treatment for COD service), observation of daily team meeting (i.e., very minimal mention of integrated treatment for COD contacts, if at all), and integrated treatment for COD services themselves may be lacking or very limited (e.g., group work only, or focused only on COD counseling for those in more active treatment stage—no work with those in earlier stages of change readiness).

	1	2	3	4	5
ST1. Co-Occurring Disorders (COD) Specialist on Team	Less than 0.25 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE COD specialist with at least minimal qualifications.

NOTE: If there is no COD specialist on the team, rate this item as a "1," but do not rate ST2 and ST3 if COD specialist vacancy has been less than 6 months. Also, rate COD specialists hired within past two months on this item, which will likely be a low rating as they likely are not yet operating fully within their specialty role, but do not rate on ST2 and ST3. If hired more than two months before review, rate new specialist on ST2 and ST3.

ST2. Role of Co-Occurring Disorders (COD) Specialist in Treatment

Definition: The co-occurring disorders (COD) specialist provides integrated treatment for COD to ACT clients who have a substance use problem. Core services include the following:
(1) Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health;
(2) Assessing and tracking clients' stages of change readiness and stages of treatment;
(3) Using outreach and motivational interviewing (MI) techniques;
(4) Using cognitive behavioral approaches and relapse prevention; and
(5) Applying treatment approaches consistent with clients' stage of change readiness.

Rationale: Individuals with concurrent severe mental illness and substance use problems will most benefit from non-confrontational stage-wise treatment that focuses on the interplay of substance use and mental illness. Yet, it is also important to address the needs of clients who are in later stages of change readiness and treat them appropriately with the recommended techniques.

DATA SOURCES (* Denotes primary data source)

Team Survey

Examine the schedule of all groups provided by the ACT team and determine which ones are targeting individuals with substance use problems (i.e., groups targeting those in earlier stages of change readiness may be more inconspicuous, such as wellness groups).

Excel spreadsheet (columns A and B)

Examine how many clients with a COD are in early vs. late stages of change readiness. How many clients are reported to be receiving individual vs. group integrated treatment for COD directly from the ACT team? Use this information to guide interview questions below.

Team Leader Interview

How are clients who need integrated treatment for COD identified? [If the team reported that less than 40% of the caseload have a co-occurring disorder, inquire for reasons for this.]	
What services are offered, and can you describe the role of the COD specialist in providing such services to clients with COD? [Listen for services offered through the team, and those the team is referring individuals to receive outside of the team.]	

Co-Occurring Disorders Specialist Interview*	
How do you come to identify who has a co-occurring substance use disorder? Can you describe the initial and ongoing assessment process? What type of assessment do you use (and should we see these in the charts)? [Ask follow-up questions, as appropriate, to determine how assessment data is being used to guide treatment strategies. Cross-reference with review of screening and assessment forms as noted in chart review above, as well as copies received from the team.]	
Please describe your treatment philosophy in working with those with both severe mental illness and substance use disorders, as well as the range of services you provide. [Depending on their response, you may want to follow-up with the following questions. If you receive more global or generic responses (e.g., "meet them where they are at"), inquire further to determine level of understanding and practice. Use client-specific information gleaned from chart reviews and/or discussion in the daily team meeting to ask follow-up questions about where selected clients are regarding stages of change readiness and examples of recent interventions. Assess for whether they are using stage appropriate interventions. Are they using outreach, MI, and harm reduction for clients in earlier stages? How is MI being used when working with clients in later stages? Are they using cognitive behavioral approaches and relapse prevention with clients in later stages?]	
What do you think is the goal for clients as it relates to their substance use? [Prompt for whether they focus on abstinence or harm reduction. If they use harm reduction, ask for specific examples.]	

Let's say you're working with a client who doesn't acknowledge that they have a substance use problem. What would be your typical approach to working with him? [Prompt to hear about specific examples of clients with whom the specialist is currently working.]	
Can you identify a client who is continuing to use, but has some awareness that her use is creating problems? Describe for me ways in which you are interacting and working with this client.	
In what ways do you use confrontation with clients regarding their use?	
Are drug/alcohol urine/blood screens ever used? *If so, with whom and for what purpose?*	
Let's say you are working with someone who says 'yes, I want to change' and voices commitment to quit or reduce his use. What interventions and/or services would you offer? [Prompt to hear about specific examples of clients with whom the specialist is currently working.]	

What about your approach to working with a client who has stopped actively using and is trying to be sober/abstinent. What types of services or interventions are offered? [Prompt to hear about specific examples of clients with whom the specialist is currently working; if not offered, ask about relapse prevention planning.] ***Are there circumstances where you would <u>not</u> provide a particular service given active substance use?*** [If examples are needed, offer: such as assisting to the grocery store, helping fill out a job application; permitting group attendance.] [If yet not clear if the specialist understands and practices stage-wise treatment, ask the following:] ***Are you familiar with stages of change readiness and treatment?*** [If yes] *How is this information collected and used? Reference Excel spreadsheet and prompt for examples of how they work with participants in different stages of change readiness.* [If the team offers groups, ask]: ***What is the focus of this group and who is invited to attend?*** [Is the group tailored to those in earlier or later stages of change? Prompt for to what extent mental illness is addressed in this group —is there effort to truly integrate mental health and COD within the group?]	

What resources (e.g., manuals, workbooks, SAMHSA IDDT Toolkit) do you use in individual and group treatment?	
Do you ever assist clients to self-help meetings? Please tell me more about that.	
If we have not yet heard of it yet, can you share with us an example of your practice that you think best reflects your work as the team's COD specialist? [With this example, try to clarify how far back the example dates.]	

ITEM RESPONSE CODING

Rating Guidelines

Please see Table 14 for a brief overview of appropriate services given the client's stage of change.

The COD specialist is the primary data source. Rely on chart review to corroborate the description of services provided by the COD specialist and the quality and timeliness of assessments. Use documented clients' stages of change readiness to approximate whether services are stage-wise and appropriate.

Please refer to Table 15 to determine if criteria are met at all, partially, or fully. To achieve a rating of "5" on this item, the COD specialist systematically screens ACT clients for substance use and conducts ongoing comprehensive assessments at least annually and assesses and ideally track client's stage of change readiness for each substance of choice every three to 6 months. Assessment forms are conducive to this task and are maintained in the client's chart. There is clear evidence that a broad range of stage-wise services are provided (in individual and/or group services), and are appropriate given the client's stage of change readiness.

Note: Penetration (i.e., percent of clients receiving the services) is not considered when rating this item as this item is focused on the quality and range of services provided; however, lower rates of penetration may suggest less consistent practice, resulting in less than "full credit" designations.

"N/A" Criteria: If no person is hired into the COD specialist position at the time of the review and the position has been open for less than six months (thereby receiving a "1" rating on ST1), or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

Table 14. Examples of Stage-Wise Integrated Treatment for Co-Occurring Disorder Interventions

	Early Stages of Change Readiness and Treatment		Later Stages of Change Readiness and Treatment	
	Pre-Contemplation	**Contemplation and Preparation**	**Action**	**Maintenance**
Stage of Change Readiness	The client does not recognize that they have a problem with substance use or has no interest in modifying use at this time.	The client recognizes that substance use is causing some problems and is considering a change. In the contemplation stage, the client is more aware about the pros & cons, but ambivalent about change; whereas in the preparation stage, the client is planning for change.	The client is committed to reducing or discontinuing substance use. Behaviors are being modified to support change.	The client has abstained from substance use for at least 6 months.
	Engagement	**Motivation**	**Active Treatment**	**Relapse Prevention**
Stage of Treatment	**Focus of treatment: Outreach**, **assessment**, **engagement**, and **building a working alliance**. Services are provided regardless of ongoing use, and include harm reduction strategies.	**Focus of treatment: Education** about substances, mental illness, and their interactions, and ongoing use of harm reduction strategies. There is a focus on **identifying pros & cons of use**. **MI** techniques are essential and include the following: • Express empathy • Offer reflective listening • Assist with goal-setting • Develop discrepancy between goals and substance use • Conduct decision balance (pros & cons) • Roll with ambivalence to change • Emphasize personal choice	**Focus of treatment**: **Helping to make change & sustaining it, with continued attention to harm reduction. Specific techniques include the following:** • MI • CBT, to include: • Managing social environments • Identifying & managing triggers and cravings • Relaxation/coping skills • $ management to avoid using • Problem-solving to reduce stress •Relapse-prevention planning	**Focus of treatment**: Maintaining abstinence. Specific techniques include the following: • Develop a relapse prevention plan • Help client attend self-help groups • Help build and maintain social supports for sobriety • Maintain awareness of vulnerability to relapse • MI • Help expand recovery to other areas of life (parent group, vocational supports)

Table 15. Role of Co-Occurring Disorders Specialist in Treatment			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Service #1: Conducting com-prehensive substance use assessments that consider the relationship between substance use and mental health.[6]	No COD assessments are conducted, are only completed minimally at intake, or are not completed by the COD Specialist.	Assessments are conducted for all clients, but are minimally focused on the interplay of mental health and substance use, and/or lack useful information. Assessments are inconsistently conducted across clients/time, which includes not consistently by the COD specialist. Partial credit is warranted if assessments are comprehensive (e.g., include a functional analysis and payoff matrix), but are only completed at intake (i.e., no follow-up assessments are completed).	COD Specialist completes COD assessments, which are documented in client charts, and these assessments gather information pertinent to the interplay of substance use and mental health (e.g., negative and positive effects of substance use activity on mental health symptoms; timeline of critical life events and stressors with substance use activity). All clients should have received a brief COD assessment at intake (when new to the team, many clients are not willing to discuss their use), while those identified as likely having COD are routinely followed up with additional comprehensive substance use assessments, ideally at least annually.
Service #2: Assessing clients' stages of change readiness and stages of treatment.[6]	There is a lack of understanding and/or documentation of stages of change readiness and treatment.	There is some understanding of the stages of change readiness and treatment, but stages are not accurately assessed and/or systematically documented. This may include documentation of stage of change or stage of treatment in other locations besides the client's medical record.	The clients' stages of change readiness and related stage of treatment are routinely and accurately assessed and documented. Ideally, this information is used to closely track progress and set-backs to identify coinciding events, mood states, etc.
Service #3: Using outreach and MI techniques.	Very little outreach is conducted and specialist does not employ MI techniques.	The specialist has a cursory understanding of MI, loosely applying techniques. Outreach may be more limited, with most of the efforts going toward those in more advanced stages of change readiness.	There is clear evidence that outreach strategies are employed to engage active users who are in earlier stages of change readiness. The specialist is adept at using MI techniques to work with clients who may be contemplating change, or needing assistance in sustaining focus on change.
Service #4: Using CBT approaches and relapse prevention.	There is limited understanding and application of CBT approaches and relapse prevention. There is very little COD counseling offered to those in later stages of change readiness.	There appears to be some understanding and application of CBT and relapse prevention, but it is more limited —clearly more individuals would benefit from advanced COD counseling.	There is clear evidence that the specialist understands and employs cognitive behavioral principles when providing COD counseling and teaching relapse prevention. Examples include attention to triggers for use, emotional reactions to triggers, learning effective coping skills, especially for how to wait out cravings.

[6] Use Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of clients in chart review sample for whom stage of change readiness or stage of treatment is document.

Table 15. Role of Co-Occurring Disorders Specialist in Treatment			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Service #5: Applying treatment approaches consistent with clients' stage of change readiness.	In review of all data sources, many examples were noted where there is an inconsistency between stage of change readiness and treatment approach (e.g., treatment was lacking all together, and or inconsistent with the stage of change readiness for many individuals).	Mixed evidence: most clients are receiving a treatment approach consistent with stage of change readiness, but a few clear exceptions were observed where treatment was not appropriate given the stage of change readiness (e.g., treatment was lacking all together, and or inconsistent with the stage of change readiness for some individuals).	Data sources indicate consistency between clients' stage of change readiness and treatment. To receive full credit, the following was observed: • No examples were noted where a client in an earlier stage of change readiness was being presented with a more advanced treatment approach, such as pushing them to attend a COD counseling class or attend AA meetings (exceptions may be when specialist intervenes more assertively due to significant safety risks); • Clients in an early stage of change readiness were receiving harm reduction interventions, and, where appropriate, MI; Later stages of change readiness clients (e.g., have voiced desire to quit and are working on it) are receiving active COD counseling and relapse prevention.

	1	**2**	**3**	**4**	**5**
ST2. Role of Co-Occurring Disorders (COD) Specialist in Treatment	The COD specialist provides 1 or fewer integrated treatment for co-occurring disorder services.	2 integrated treatment for COD services are provided (3 are absent).	3-4 integrated treatment for COD services are provided, (1 or 2 are absent) OR ALL 5 services are provided, with 3 or more services PARTIALLY provided.	ALL 5 integrated treatment for COD services are provided, but up to 2 services are only PARTIALLY provided.	ALL 5 integrated treatment for COD services are FULLY provided.

ST3. Role of Co-Occurring Disorders Specialist within Team

Definition: The co-occurring disorders (COD) specialist is a key team member in the service planning for clients with COD. The COD specialist performs the following functions WITHIN THE TEAM:
(1) Modeling skills and consultation;
(2) Cross-training to other staff on the team to help them develop co-occurring disorder assessment and treatment skills;
(3) Attending all daily team meetings; and
(4) Attending the majority of treatment planning meetings for clients with COD.

Rationale: The COD specialist appropriately influences fellow team members' practices with co-occurring disordered clients so that clients receive optimal integrated treatment for COD across the team.

DATA SOURCES (* Denotes primary data source)

Daily Team Meeting

Observe whether and how the COD specialist contributes to discussions related to COD during the daily team meeting. Do they appear to be referred to within the team?

Co-Occurring Disorders Specialist Interview*

How often do you attend the daily team meetings? What do you see as your role in that meeting?	
How often do you attend treatment planning meetings? *How do you select the ones you attend?* ***What do you see as your role in that meeting?*** [Prompt for examples]	
Have you provided more formal trainings to the team related to your area of specialty? *When, how often, what was the topic?*	
Do you ever provide more individual consultation with team members? [If yes:] *How often? Can you give me* an example?	
Is there any part of your role that you find to be challenging to fulfill or carry out day-to-day?	
Are there areas of education or training you think would be helpful for you to do an even better job in your role?	

Clinician Interview	
Now we want to better understand how fellow team members may impact your practice. ***How has your work with clients with co-occurring substance use disorders been influenced by the COD specialist?*** *Do they help you in your work with clients with COD? In what ways do you see them as a resource to you?*	

ITEM RESPONSE CODING

General Frequency Guidelines

- **Modeling and Consultation**: Modeling includes demonstration of behaviors and attitudes consistent with the integrated treatment for COD in meetings or in the field. To receive credit, they are not expected to be full-fledged experts in integrated treatment for COD, but are gaining expertise and are viewed as more expert in integrated treatment for COD than other team members. Consultation includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation) and/or education specific to the specialist's content area provided frequently, such as at least monthly within the past 6 months.
- **Cross-training:** Includes formal training (e.g., didactic, skill-based teaching) to other team members at least 20 minutes in duration provided at least one time in the past 6 months. To receive credit, the topic area should be judged to be relevant and helpful given the evidence-based practice guidelines.
- **Daily Team Meetings:** Regularly attends all daily team meetings (except when pre-planned activities conflict with meeting) at a rate commensurate with their hours and schedule with the team. If the team meets four days a week, which is the rate at which the specialist attends, credit for this function. However, if the team is meeting less often than three days a week, then do not credit for this function. Similarly, credit if the specialist works 4x10-hour shifts each week and attends four days per week.
- **Treatment Planning Meetings:** Attends the majority of treatment planning meetings for clients with COD. To receive credit, the specialist(s) attends planning meetings for at least 50% of those with COD, where such meetings are held every 6 months. If held less often than 6 months, no credit for this function is to be given.

Rating Guidelines

Use the interview with the COD specialist as primary data source. Cross-reference with the interview with the clinician. Reconcile any discrepancies with follow-up interview questions with the team leader. To receive full credit, the COD specialist provides all of four these services within the team.

"N/A" Criteria: If no person is hired into the COD specialist position at the time of the review (thereby receiving a "1" rating on ST1), or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

ST3. Role of Co-Occurring Disorders (COD) Specialist within Team	1	2	3	4	5
	The COD specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.

ST4. Employment Specialist on Team

Definition: The team has at least 1.0 FTE team member designated as an employment specialist, with at least one year of experience providing employment services (e.g., job development, job coaching, supported employment). Ideally, the ACT employment specialist is a part of a larger supported employment & education (SEE) program within the agency.

Rationale: ACT teams emphasize skill development and support in natural settings. Fully integrated ACT teams include employment and educational services that enable clients to find and keep jobs in integrated work settings. As a result, it is essential to include a dedicated position to lead these strategies.

DATA SOURCES (* Denotes primary data source)

Team Survey

Refer to response to item #1, noting FTE and qualifications.

Excel spreadsheet (column E)

How many clients are reported to be receiving employment and educational services directly from the ACT team?

Chart Review

Cross-walk what specialists report as the percent of contacts that involve specialist services with what is observed in the review of progress note entries (e.g., what percent of progress note entries by employment specialist have some notation of employment and education services, inclusive of assessment and engagement?). Significant discrepancies may warrant an adjustment from what was reported and what was observed in the chart (e.g., specialist reports 90%, and chart review data finds only 50%; in such a case, given what other data sources indicate (e.g., scheduling practices), reducing to 70% may be a more accurate reflection of how the specialist is used in his or her role).

Employment Specialist Interview*

Please tell us about your training and experience in delivering employment and educational services.	
Are you connected to a larger employment program within your agency? [If yes, inquire as to how the agency supported employment and education (SEE) program and ACT team are situated within the agency, and the employment specialist's role with both programs. This additional information provides helpful context for the evaluation of the vocational program. Ideally, the employment specialist is a part of a larger SEE program, but is fully integrated on to the ACT team.]	
Do you provide services to non-ACT clients? [If yes:] *Approximately how much of your time is devoted to non-ACT clients?*	

If you were to think of a typical week, what percentage of your time involves some type of employment and educational service, including outreach, engagement, and job development? ***Are you assigned as the primary care provider or coordinator for any clients? If so, how many and, of those, who have expressed employment and educational service needs?*** [This additional information provides context for how the specialist(s) may be employed within the team. As needed, further inquire about how caseload assignments are made (as primary, and/or as part of ITTs).] **Note:** Specialists can use opportunities to conduct case management type interventions to engage clients around specialty. Cause for concern is when the specialist has to fill another need on the team, which prevents him or her from providing specialty interventions.	

ITEM RESPONSE CODING

Inclusion Criteria

If two specialists are on the team: It is acceptable and encouraged to consider the cumulative percent of time devoted to specialty services for up to two individuals serving in this specialty role. Please see the note in the rating guidelines section regarding inclusion of team members who may not be formally designated as a specialist, but have assumed more specialty service responsibilities.

Exclusion Criteria

Refer to OS1 for general inclusion and exclusion criteria (e.g., at least 16 hours of week with team, attending at least two daily team meetings per week).

Rating Guidelines and Formula

Several criteria are considered when determining the rating for ST4. These criteria include the following:

1. Reported time in position (i.e., FTE);
2. Actual time devoted to specialty-related activities[1] while in the position; and
3. Qualifications of the specialist(s).

NOTE: Up to two team members may be considered in this rating. Even if the team formally has one team member designated as the employment specialist, evaluators are encouraged to prompt the team leader prior to the fidelity review to determine whether there is any other team member who assumes greater responsibility for delivering employment and educational services (see fidelity review orientation letter in Appendix A). Even if this secondary "employment specialist" does not meet minimal qualifications, they may positively contribute to this rating, which is in the spirit of the team sharing responsibility for services.

To Rate ST4, input data obtained from pre-fidelity survey and interviews into Table 16. Then use these data to complete Steps 1 – 3 below. If only one specialist on team, skip Step 2.

Table 16. Summary of Data Used to Rate Employment Specialist on Team		Employment Specialist	
	Criteria	**Primary Specialist**	**Secondary Specialist (if applicable)**
A	FTE with ACT team (see pre-fidelity survey and interview data; (FTE = # of hours employed with ACT per week / 40))		
B	Time devoted to specialty-related activities[1]: estimated % of client contacts that involve an employment and educational service (interview data, cross-checked with other data sources[2])		
C	Meets minimal qualifications, which entails meeting local standards for certification or licensure as an employment specialist and has at least one year experience providing employment services and/or has advanced education that involved field training in employment and educational services (see under Step #3 below)		

Step 1. Determine Provisional Rating Given the Adjusted FTE (Criteria A and B in Table 16)

***Please refer to the TMACT Calculation Workbook to enter and compute these data.

a. **If *80% or more* of client contacts involve specialist-related activities** (criterion B), per specialist report and other sources[2], **give full credit for the reported FTE on the team** (criterion A). Refer to Table 17 to determine provisional rating (Note: it remains "provisional" because we have yet to examine the impact of qualifications).
Example a1: Specialist is 1.00 FTE (i.e., 40 hrs/wk) and reports that 90% of contacts involve employment specialty and other sources support that estimate, then 1.00 FTE (i.e., actual FTE) is used, which provisionally rates a "5" based on Table 17.

b. **If less than 80% of client contacts involve specialist-related activities** (criterion B), per specialist reports and/or other sources[2], calculate an adjusted FTE, which is then used to determine the provisional rating based on Table 17.

Table 17. Provisional Ratings Following Step 1.

FTE	Rating
1.00 +	5
0.75 – 0.99	4
0.50 – 0.74	3
0.25 – 0.49	2
0.00 – 0.24	1

Calculating the Adjusted FTE =

Full-Time

- **If the specialist is full-time with the team** (i.e., 1.0 for criterion A in Table 16)**:** Add 10 to the estimated percent of time dedicated to specialist role (criterion B in Table 16), and divide by 100.
Example b1: A full-time employment specialist reported, and other data sources corroborated, that 50% of her time was spent providing specialty services. Her adjusted FTE would then be 50 + 10 = 60 / 100 = 0.60 Adjusted FTE, provisionally rating a "3" based on Table 17. (Note: it remains "provisional" because we have yet to examine impact of qualifications)

- **If the specialist is part-time with the team** (i.e., less than 1.0 FTE reported for criterion A in Table 16)**,** use the following formula to calculate the adjusted FTE:

Part-Time

(FTE on team, which is criterion A in Table 16) * (percent of client contacts involving specialty-related activities[1] which is criterion B in Table 16)) +.05.

Example b2: An employment specialist was employed with the team for 24 hours a week, or 0.60 FTE. She estimated that 50% of her time was spent providing specialty services. (0.60 (FTE on team, or criterion A) * 0.50 (representing 50%, or criterion B)) + 0.05 = 0.35 Adjusted FTE, which provisionally rates a "2" based on Table 16.

Step 2. (Only complete if there are two specialists; otherwise skip to Step 3)

Aggregating FTE for Two Specialists: If two specialists are present, then go through Step 1 above for each specialist and add together the total adjusted FTE time and determine provisional rating based on Table 17.

Example c: A team has a designated employment specialist who is full-time (1.0 FTE) with the team. He reported that at least 75% of his client contacts involve employment and educational services; the evaluators could not find data that supported such a high estimate (e.g., only 25% of his chart note entries reflected any specialty services) and agreed that 50% was more accurate.

A second team member was interviewed; this person has been a longtime champion of competitive work and provides various supports for working clients. She works with the team four days a week at 0.80 FTE. She estimated that, of all the clients she meets with in a typical week, approximately 35% involve an employment and educational service. The evaluators found other evidence to support estimate.

Employment specialist 1 (full-time): **(50** (reflecting the 50% estimated time in role) **+ 10** (formula instructions to add "10")**) / 100 = 0.60** Adjusted FTE.

Employment specialist 2 (part-time): (0.80 (reflecting her FTE on the team) *** 0.35** (reflecting 35% time in specialty role)**) + 0.05** = **0.33** Adjusted FTE.

Aggregate Adjusted FTE = 0.60 + 0.33 = 0.93 Total Adjusted FTE (Provisional "4" rating based on Table 17—recall, it remains "provisional" as we have yet to determine impact of qualifications standard).

Step 3. Qualifications Determination for Final Rating (criterion C in Table 16)

a. One specialist on team (see Step 1 examples above):

- **The provisional rating becomes final rating if the following qualifications are met:** Has at least one year experience providing employment services and/or has advanced education that involved field training in employment and educational services. Experience may include time spent in the current position only if specialist is at least 0.50 FTE and at least 65% of client contacts involve specialist-related activities. Preferably the specialist has training or experience in individual placement and support model (i.e., specific form of SEE that emphasized individual preferences and prompt placement in competitive employment).
- **The provisional rating is *adjusted down* to next lowest rating if above minimal qualifications are not met** (i.e., If the specialist in example a did not meet minimal qualifications, then her provisional "5" rating is reduced to a "4" rating; if specialist in example b1 did not meet minimal qualifications, her provisional "3" rating is reduced to a "2" rating).

b. Two Specialists on team (see Step 2 examples above):

- **Two unqualified staff:** The provisional rating is adjusted down to next lowest rating if *both* specialists do not meet above minimal qualifications.
- **One qualified and one unqualified staff:** If one specialist meets qualifications, but the other does not, then the final rating is the higher of the following two options: a) final rating is based solely on the one qualified staff or, b) final rating based on two unqualified staff (i.e., in example c described above, assume that Specialist 1 (adjusted

FTE of.60) met qualifications, but Specialist 2 (adjusted FTE of.33) did not. Their aggregate FTE is 0.93 FTE (provisional "4" rating), and would be reduced to a "3" as one specialist does not meet qualifications (option b). Alternatively, we could rate based only on the one qualified staff, Specialist 1 (option a). However, her adjusted FTE of 0.60 only earns a "3" rating on its own. Thus, in this example, both options result in a "3" rating.

[1] **Specialist-related activities**: Estimated percent of client contacts that involve any activity associated with the specialty area. Qualifying client contacts include those where engagement practices are delivered while providing other case management services, as well as more obvious specialty-related interventions or assessments. To get full credit (i.e., to be rated according to actual FTE with the team), *at least 80%* of client contacts should involve a specialty-related activity.

[2] **Supporting specialists' estimations:** Evaluators are encouraged to consider other data sources to gauge the approximate amount of time spent in specialist activities. Evaluators should first consider the specialist's estimation, then cross-check that estimation with other data sources, such as activities reported in the daily team meeting, noted in the client log, and progress notes. If a significant discrepancy occurs, then evaluators should adjust this percentage, discussing with the specialist if possible to agree on a more accurate percentage of time devoted to specialist activities. Otherwise, evaluators should adjust reported percentage, keeping in mind the following heuristic guidelines:

- For a specialist who provides a *high degree* of employment and educational services (e.g., 80% or more), it is assumed that such a high level of practice will be evident across multiple data sources—e.g., chart review (majority of notes (at least 60%) written by this specialist indicates some employment and educational service), observation of daily team meeting (i.e., reported contacts involving employment and educational services, and scheduled contacts to address client's vocational needs), and a large breadth of employment and educational services are provided.
- For a specialist who provides a *moderate degree* of employment and educational services (e.g., 40% - 60%), it is assumed that a moderate level of practice will be evident across several data sources—e.g., chart review (some notes (e.g., 20% - 60%) written by this specialist indicates employment and educational service), observation of daily team meeting (i.e., reported contacts involving employment and educational services, and scheduled contacts to address client's vocational needs), the breadth of employment and educational services being provided may vary.
- For a specialist who provides a *low degree* of employment and educational services (e.g., 10% - 30%), it is assumed that there will be little evidence of such practice across multiple data sources—e.g., chart review (very few notes (< 20%) written by this specialist indicates some employment and educational service), observation of daily team meeting (i.e., very minimal mention of employment and educational services, if at all), and employment and educational services themselves may be lacking or very limited (e.g., majority of employment and educational services consists of helping clients prepare for job searches, such as resume development and assessment).

	1	2	3	4	5
ST4. Employment Specialist on Team	Less than 0.25 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE employment specialist with at least minimal qualifications.

NOTE: If there is no employment specialist on the team, then rate this item a "1," but do not rate ST5 and ST6 if employment specialist vacancy has been less than 6 months. Also, rate employment specialists hired within past two months on this item, which will likely be a low rating, but do not rate on ST5 and ST6. If hired more than two months before review, rate new specialist on ST5 and ST6.

ST5. Role of Employment Specialist in Services

Definition: The employment specialist provides supported employment & education services. Core services include the following:
(1) Engagement;
(2) Vocational assessment;
(3) Job development;
(4) Job placement (including going back to school, classes);
(5) Job coaching & follow-along supports (including supports in academic settings); and
(6) Benefits counseling.

In addition to the idea of client choice as sole criterion and limited prevocational assessment, there are no requirements for demonstrating "work readiness," (e.g. demonstrating punctuality, participation in work crews).

Rationale: Work is integral to the recovery process for many clients and research has shown that following the core principles of Supported Employment & Education (SEE) lead to better work outcomes for adults with severe mental illness.

The core employment and educational services, which reflect the key principles of the evidence-based SEE model, assessed in this item are included in the table below:

DATA SOURCES (* Denotes primary data source)

Excel spreadsheet (columns E-I, and L)

Examine how many clients are working, where they are working, the type of position, how they got the position, and the number of clients receiving employment and educational services to guide interview questions. Note how many clients may be receiving other services (e.g., clubhouse) and the extent to which they're receiving them in lieu of what the employment specialist and ACT team provides.

Team Leader Interview

Describe the variety of services provided by the employment specialist [Prompt for roles described above.]	
Can you think of any agency policies that get in the way of providing supported employment & education services (e.g., cannot assist when someone is actively abusing drugs)?	

Employment Specialist Interview*	
Can you describe the range of employment and educational services that you provide? [Use their responses to guide whether you ask the questions listed below, and use reflections and summaries as it pertains to below questions as you receive information here.]:	
How do you motivate clients to consider competitive work? [Seek examples of how employment specialist may bring up the subject of work with clients. Also ask if they have received any training in motivational interviewing, and if so, how that is used in engagement.]	
Can you describe the vocational assessment process? *What forms are used? What information is collected?* [Specifically ask if they are using the Career Profile.]	
How is it determined who is assessed and when assessments are completed?	
How is the information that is gathered in the assessment used? [Listen for language pertaining to job search and ongoing supports and ask for examples in who has an assessment and how it has been used. Also ask to see a completed assessment if you do not see one in the chart review.]	

Think about a recent person you helped to get a job or go back to school. What was the timeframe between their voicing interest and subsequent steps (e.g., completing assessment, reaching out to employers, and getting the job)? [Refer to Excel spreadsheet for specific examples of clients the team reported the team assisted in getting a job.] ***Do you do any job development?*** [If a description is needed, job development entails reaching out to local employers and businesses to develop relationships and discover potential right-fit job matches.] [If yes, ask for examples of businesses the specialist has visited for job development, whether a tracking sheet listing dates of contact is maintained that includes person contacted, summary and plan.] [If yes to job development] ***Can you share with me what you say when your approach employers for job development?*** ***What kind of follow-along supports do you provide?*** *Could you give an example of the last time you did job coaching — when was that? What about follow-along supports or coaching for those clients who are going back to school?* ***What is your understanding of how work may impact benefits, and work incentive programs. Do you provide benefits counseling?*** Ask for examples.	

How many clients are currently working in a competitive setting? (Cross-reference with *Excel spreadsheet*). ***What about clients working in noncompetitive settings (e.g., volunteer, transitional employment, work crews)—what are those settings?***	
How do you help match clients to jobs or placements? (Look for language suggesting that this is a client-driven process; present an ambitious "dream job" scenario to understand the follow-up questions and responses.)	
Of all the businesses employing clients, which one employs the highest number—what number is that? (Response provides some information about job preferences -- e.g., if 50% are employed at the same business, then it is doubtful that they all wanted a similar job.)	
Do you ever help clients go back to school or access courses if they haven't ever been in school? Ask for examples.	
If we have not yet heard of it yet, can you share with us an example of your practice that you think best reflects your work as the team's employment specialist? [With this example, try to clarify how far back the example dates.]	

Client Interview	
Is there anyone here who is currently working or has worked in past year? Have any of you recently gone back to school? Tell me about your work/school. Did the team help you get and keep that job or stay in school? [Look for examples of how the employment specialist assists clients around employment or school goals and whether there appears to be a focus on competitive employment. Attend to whether there is clear interest in working that is not being addressed by team, esp. employment specialist.]	

ITEM RESPONSE CODING

Rating Guidelines

Primarily rely on information provided by employment specialist (s), but consider all information gathered across sources and investigate discrepancies. Review progress notes of clients who are receiving employment and educational services; these notes may be weekly summary notes. Refer to Table 18 below to determine if criteria are met at all, partially, or fully. If all six services are provided by the employment specialist (s), rate as a "5."

"N/A" Criteria: If no person is hired into the employment specialist position at the time of the review (thereby receiving a "1" rating on ST4), or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

Table 18. Role of Employment Specialist in Services

Service	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Service #1: Engage-ment	There is very limited evidence of engagement activities when reviewing multiple data sources (e.g., progress notes, client log, client interviews).	There is some evidence of engagement, but this does not appear to be a result of a planned strategy (e.g., work is conveniently discussed while taking a client shopping). OR There is evidence that *who* is targeted for engagement is based on inconsequential attributes (e.g., sobriety, medication adherence, symptom stability).	The specialist increases clients' interests in the prospect of work and educates them about their opportunities and the benefits of working. There is concerted effort to be scheduled to meet with clients for engagement, even if within the context of delivering another service. Ideally, the specialist is skilled at MI, using such techniques to address ambivalence about working. It is not uncommon for the whole team to assume a larger role in engagement strategies; however, it should not be at the exclusion of the specialist typically taking the lead in most cases.

Table 18. Role of Employment Specialist in Services			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Service #2: Vocational assess-ment[7]	No vocational assessment is conducted and documented, OR The vocational assessment process is needlessly lengthy and stalls the actual job placement, where more useful assessment data may be collected.	The prevocational assessment is limited in its utility given the information that is gathered, and/or is inconsistently conducted and documented. There is little evidence of attending to client preferences. There is limited appreciation for collecting assessment data while the client is employed. Partial credit is also warranted if the initial assessment is comprehensive but there are no updated assessments.	The specialist conducts assessments to gather information about work history, strengths, and interests, as well as the extent to which symptoms may have interfered with previous jobs. Employment specialist assesses for clients' preferences, especially regarding disclosure of mental illness and degree of employment specialist's involvement. The assessment itself (or Career Profile) serves a living document, guiding both job searches abut also how to provide ongoing supports. Completion of a prevocational assessment should not delay efforts to focus on job placement itself. More useful assessment information is gathered once client has been placed in a job. To receive full credit, vocational assessment data are complete, updated, and reflecting most or all of the information described above.
Service #3: Job develop-ment	Job development is focused on employment that is not competitive. Or job development is not provided, or provided very minimally (e.g., only one or two examples were provided, dating back to previous year).	Some recent examples of job development are provided, but this important task is clearly not prioritized, is not driven by client preferences and/or has artificial parameters (e.g., specialist only conducts job development in limited areas -- geographical, vocational area/employer). Job development is conducted less often than the equivalent of one day a week per 50 clients.	Specialist develops relationships with local businesses through systematic job development and educates them about the services that the employment specialist provides, collects information about positions, and, ideally, determines potential for job carving options (e.g., whether the duties of one part-time position could be broken into two part-time positions). The equivalent of at least one day a week per 50 clients is devoted to job development.
Service #4: Job placement (including going back to school, classes)	Job placement is not customized to meet clients' preferences (e.g., specialist relies on a couple of go-to employers). If specialist considers behaviors or symptoms they believe reflect "work readiness," beyond mere expression of one's desire to work or return to school, such as substance use, medication adherence, and symptom stability, then rate as no credit if "work readiness" criteria appear to significantly impact job placement activities.	Job placement is somewhat customized (i.e., there is attention to preferences, but a reliance on select employers) and/or placement itself is not "rapid" (i.e., there is considerable delay between voiced interest in work and contact with employers). If specialist considers behaviors or symptoms they believe reflect "work readiness" beyond mere expression of one's desire to work or return to school, such as substance use, medication adherence, and symptom stability, then rate partial if "work readiness" criteria appear to minimally impact job placement activities.	Specialist assists clients in locating jobs that meet their preferences, and does so in a rapid manner. There is a relatively short amount of time (fewer than 30 days) between when the client voices interest in working and initial contact with an employer. Specialist assists with completing applications, resumes, and role-playing interviews. This could also include assistance with going back to school or accessing coursework.

[7] Use the Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of charts that included a vocational assessment in line with supported employment & education principles.

Table 18. Role of Employment Specialist in Services			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Service #5: Job coaching & follow-along supports (including supports in academic settings)	Follow-along support is not provided, or on very rare occasion.	Some evidence of follow-along supports was observed, but this activity was clearly limited (e.g., examples reflected phone support with clients, with no examples of face-to-face on/off site job coaching).	Per the client's preferences and consent, specialist provides support on/offsite to assist client in training and learning skills needed for job, can serve as a liaison between client and employer, and problem-solves issues as they arise. Although examples of on-site job coaching are not necessary for full credit, the absence of job coaching should not be due to a lack of skills on the part of the specialist. This role also includes providing supports in academic settings.
Service #6: Benefits counseling	Benefits counseling is not provided by the specialist, or is extremely limited in content and application. Specialist rarely assists clients in obtaining this information from another source.	Specialist's benefits knowledge is limited (e.g., specialist is aware of how benefits are impacted by work, but unaware of programs that may maximize on clients' return, such as PASS), and/or benefits counseling is not widely provided.	Every step of the way, specialist is providing counseling to the client regarding their benefits and how they are affected by varying levels of employment, providing clients with information to help them to make informed decisions about returning to work. NOTE: The expectation is not for the specialist to know all of the in's and out's of SSI/SSDI, but it is important for them to at least know the fundamentals and be actively involved in working with the client to schedule meetings with a benefits counselor who may know more of these specifics. There is also expectation that the specialist understands enough about how work impacts benefits to correct misinformation, and to use educational strategies as part of engagement.

	1	**2**	**3**	**4**	**5**
ST5. Role of Employment Specialist In Services	The employment specialist provides 2 or fewer employment services.	3 employment services are provided (3 are absent) OR 4 services are PARTALLY provided (2 are absent).	4 employment services are provided (2 are absent), but up to 3 services are only PARTIALLY provided OR 5 employment services are provided (1 is absent) OR ALL 6 services are provided, with 4 or more PARTIALLY provided.	ALL 6 employment services are provided, but up to 3 services are only PARTIALLY provided.	ALL 6 employment services are FULLY provided.

ST6. Role of Employment Specialist within Team

Definition: The employment specialist is a key team member in the service planning for clients who want to work or are currently working. The employment specialist performs the following functions WITHIN THE TEAM:
(1) Modeling skills and consultation;
(2) Cross-training to other staff on the team to help them to develop supported employment & education approaches with clients in the team;
(3) Attending all daily team meetings; and
(4) Attending all treatment planning meetings for clients with employment goals.

Rationale: The employment specialist influences fellow team members' practices with clients by motivating team members to discuss work more often with clients, conduct preliminary assessments, and provide ongoing supports.

DATA SOURCES (* Denotes primary data source)

Daily Team Meeting

Observe whether and how the employment specialist contributes to discussions related to employment and/or school during the daily team meeting. Do they appear to be referred to within the team?

Employment Specialist Interview*

How often do you attend the daily team meetings? What do you see as your role in that meeting?	
Do you attend treatment planning meetings for the clients who have employment or education goals? *How do you select the ones you attend?* ***What do you see as your role in that meeting?*** [Prompt for examples.]	
Have you provided more formal trainings to the team related to your area of specialty? [Prompt for details - *when, how often, what was the topic?]*	
Do you ever provide more individual consultation with team members? [If yes:] *How often? Can you give me* an example?	
What parts of your role do you find to be challenging to fulfill or carry out day-to-day?	
What areas of education or training do you think would be helpful for you to do an even better job in your role?	

Clinician Interview	
How has your work with clients been influenced by the employment specialist? *Do they help you in any way to better work with clients who have employment goals? In what ways do you view the employment specialist as a resource to you?*	

ITEM RESPONSE CODING

General Frequency Guidelines

- **Modeling and Consultation**: Modeling includes demonstration of behaviors and attitudes consistent with evidence-based SEE in meetings or in the field. To receive credit, they are not expected to be full-fledged experts in SEE, but are gaining expertise and are viewed as more expert in SEE than other team members. Consultation includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation) and/or education specific to the specialist's content area provided frequently, such as at least monthly within the past 6 months.
- **Cross-training:** Includes formal training (e.g., didactic, skill-based teaching) to other team members at least 20 minutes in duration provided at least one time in the past 6 months. To receive credit, the topic area should be judged to be relevant and helpful given the evidence-based practice guidelines.
- **Daily Team Meetings:** Regularly attends all daily team meetings (except when pre-planned activities conflict with meeting) at a rate commensurate with their hours and schedule with the team. If the team meets four days a week, which is the rate at which the specialist attends, credit for this function. However, if the team is meeting less often than three days a week, then do not credit for this function. Similarly, credit if the specialist works 4x10 hour shifts each week and attends four days per week.
- **Treatment Planning Meetings:** Attends the majority of treatment planning meetings for clients with employment or education goals (long-term or short-term goals/objectives). To receive credit, the specialist attends planning meetings for at least 50% of those with employment or education goals, where such meetings are held every 6 months. If planning meetings are held less often than 6 months, no credit for this function is to be given.

Rating Guidelines

Use the interview with the employment specialist as primary data source. Cross-reference with interview with clinician. Reconcile any discrepancies with follow-up interview questions with the team leader. To receive full credit, the employment specialist provides all four functions within the team.

"N/A" Criteria: If no person is hired into the employment specialist position at the time of the review (thereby receiving a "1" rating on ST4) or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

	1	2	3	4	5
ST6. Role of Employment Specialist Within Team	The employment specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.

ST7. Peer Specialist on Team

Definition: The team has at least 1.0 FTE team member designated as a peer specialist who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following:
(1) Self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services;
(2) Is in the process of their own recovery; and
(3) Has successfully completed training in wellness management and recovery (WMR) interventions.

Rationale: Peer specialists play an important role within ACT, delivering a range of practices across the service continuum, including WMR services. Some research has concluded that including clients as staff on case management teams improves the practice culture, making it more attuned to client perspectives and person-centered approaches to care.

DATA SOURCES (***** Denotes primary data source)

Team Survey*

Refer to item #1, noting FTE and qualifications. Is there more than one peer specialist on the team?
If there is more than one specialist, then separate out qualified and unqualified FTE time.

Excel spreadsheet (column K)

How many clients are reported to be receiving formal and/or manualized WMR services directly from the team? This may help gauge the percent of time dedicated to specialist role (I.e., whether an adjusted FTE should be calculated), although it is possible that only informal WMR strategies are being used. _____

Chart Review

Cross-walk what specialist's report as the percent of contacts that involve specialist services with what is observed in the review of progress note entries (e.g., what percent of progress note entries by peer specialist have some notation of WMR services, inclusive of assessment and engagement, and both formal and informal WMR?)

Peer Specialist Interview*

Have you completed any formal training in wellness management and recovery interventions? (e.g., peer counselor training, Wellness Recovery Action Plans (WRAP), IMR; note that the peer specialist does not need to have received training in these example interventions to meet criterion #3.)	
What experiences make you qualified to be the team's peer support specialist? [Listen for whether minimal qualifications have been met, and follow-up with additional questions, as needed.]	

Are you assigned as the primary care provider or coordinator for any clients? If so, how many? How did you come to be assigned to be the primary for those clients? [This additional information provides context for how the specialist(s) may be employed within the team.] ***Approximately what percentage of your time is spent providing services specific to your specialty (e.g., WMR services, client advocacy)? In other words, if you were to think of a typical week, what percentage of client contacts involve some type of peer specialist services, including outreach and engagement?*** [Further probe for how much of their time is spent doing basic case management and/or paraprofessional tasks— e.g., medication deliveries, wellness check-ins, and transportation. Although peer-related services can be paired with case management services, they should not be exclusively delivered within the context these services.]	

ITEM RESPONSE CODING

Inclusion Criteria

If two specialists are on the team: It is acceptable and encouraged to consider the cumulative percent of time devoted to specialty services for up to two individuals serving in this specialty role. Please see the note in the rating guidelines section regarding inclusion of team members who may not be formally designated as a specialist, but have assumed more specialty service responsibilities.

Exclusion Criteria

Refer to OS1 for general inclusion and exclusion criteria (e.g., at least 16 hours of week with team, attending at least two daily team meetings per week).

Rating Guidelines

Several criteria are considered when determining the rating for ST7. These criteria include the following:

1. Reported time in position (i.e., FTE);
2. Actual time devoted to specialty-related activities[1] while in the position; and
3. Qualifications of the specialist(s). *See notes following Step 3.*

NOTE: Up to two team members may be considered in this rating. Even if the team formally has one team member designated as the peer specialist, evaluators are encouraged to prompt the team leader prior to the fidelity review to determine whether any other team member who assumes greater responsibility for delivering peer support services (see fidelity review orientation letter in Appendix A). Even if this secondary "peer specialist" does not meet minimal qualifications, they may positively contribute to this rating, which is in the spirit of the team sharing responsibility for services.

To rate ST7, input data obtained from pre-fidelity survey and interviews into Table 19. Then use these data to complete Steps 1 – 3 below.

Table 19. Summary of Data Used to Rate Peer Specialist on Team		Peer Specialist	
	Criteria	Primary Specialist	Secondary Specialist (if applicable)
A	FTE with ACT Team (see pre-fidelity survey and interview data; (FTE = # of hours employed with ACT per week / 40))		
B	Time devoted to specialty-related activities[†]: estimated % of client contacts that involve a peer support service (interview data, cross-checked with other data sources[‡])		
C	Meets minimal qualifications, which entails meeting local standards for certification as a peer specialist. If peer certification is unavailable locally, minimum qualifications include the following: (1) self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) is in the process of their own recovery; and (3) has successfully completed training in WMR interventions (see under Step #3 below).		

Step 1. Determine Provisional Rating Given the Adjusted FTE (Criteria A and B in Table 19)

***Please refer to TMACT Calculation Workbook to enter and compute these data.

a. **If *80% or more* of client contacts involve specialist-related activities** (criterion B, per specialist report and other sources[‡]), **give full credit for the reported FTE on the team (criterion A).** Refer to Table 20 for provisional rating. (Note: it remains "provisional" because we have yet to examine impact of qualifications).
Example a: The specialist is 0.80 FTE (i.e. 32 hrs/wk) and reports that 90% of contacts involve peer specialty and other sources support that estimate, then 0.80 FTE is used (i.e., actual FTE), which provisionally rates a "4" based on Table 20).

b. **If less than 80% of client contacts involve specialist-related activities** (criterion B), per specialist reports and/or other sources[‡]) calculate an adjusted FTE, which is used to determine the provisional rating based on Table 20.

Table 20. Provisional Ratings Following Step 1.

FTE	Rating
1.00 +	5
0.75 – 0.99	4
0.50 – 0.74	3
0.25 – 0.49	2
0.00 – 0.24	1

Calculating the Adjusted FTE =

- **If the specialist is full-time with the team** (i.e., 1.0 for criterion A in Table 19)**:** Add 10 to the estimated percent of time dedicated to specialist role (criterion B in Table 19), and divide by 100.
Example b1: A full-time peer support specialist reported, and other data sources corroborated, that 50% of her time was spent providing specialty services. Her adjusted FTE would then be 50 + 10 = 60 / 100 = 0.60 Adjusted FTE, provisionally rating a "3" based on Table 20. (Note: it remains "provisional" because we have yet to examine impact of qualifications)
- **If the specialist is part-time with the team** (i.e., less than 1.0 FTE reported for criterion A in Table 19), use the following formula to calculate the adjusted FTE:
((FTE on team, which is criterion A in Table 19) * (percent of client contacts involving specialty-related activities[1], which is criterion B in Table 19)) + 0.05.
Example b2: A peer support specialist was employed with the team for 24 hours a week, or 0.60 FTE She estimated that 50% of her time was spent providing specialty services.
(0.60 (FTE on team, or criterion A) *** 0.50** (representing 50%, or criterion B**)) + 0.05 = 0.35** Adjusted FTE, which provisionally rates a "2" based on Table 20.

Step 2. (Only complete if there are two specialists; otherwise skip to Step 3)

Aggregating FTE for Two Specialists: If there are two specialists in position, go through Step 1 for each specialist and add together total adjusted FTE time. Determine provisional rating, Table 20.

Example c: A team has a designated peer support specialist who is full-time (1.0 FTE) with the team. He reported that at least 75% of his client contacts involve peer support services; the evaluators could not find data that supported such a high estimate (e.g., only 25% of his chart note entries reflected any specialty services) and agreed that 50% was more accurate.

A second team member was interviewed; this person has been a recipient of mental health services in the past and has been open about this with clients, as well as assuming some responsibility for leading a WRAP group. She works with the team four days a week at 0.80 FTE. She estimated that, of all the clients she meets with in a typical week, approximately 25% involve a peer support service. The evaluators found other evidence to support that estimate.

Peer Support specialist 1 (full-time): **(50** (reflecting the 50% estimated time in role) **+ 10** (formula instructions to add "10")**) / 100** = **60 / 100 = 0.60** Adjusted FTE.

Peer Support specialist 2 (part-time): (0.80 (reflecting her FTE on the team) *** 0.20** (reflecting 25% time in specialty role)**) + 0.05 = 0.33** Adjusted FTE.

Aggregate Adjusted FTE = 0.60 + 0.33 = 0.93 Total Adjusted FTE (Provisional "4" rating, Table 20 – recall, it remains "provisional" as we have yet to determine impact of qualifications standard)

Step 3. Qualifications Determination for Final Rating (criterion C in Table 19).

One specialist on team (see Step 1 examples above):

- **Provisional rating becomes final rating if the following qualifications are met:** Meets local standards for certification or licensure as a peer specialist. If peer certification is unavailable locally, minimum qualifications include the following: (1) self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) is in the process of their own recovery; and (3) has successfully completed training in WMR interventions. Although not required, it is preferred that the peer has had similar experiences as ACT clients, such as having recovered from a psychiatric illness common of ACT clients), having been a recipient of public mental health services, and/or has experienced complications typical of living with a serious mental illness, such as hospitalization, stress within the family, and psychotropic medication side effects).
- **Provisional rating is adjusted down to next lowest rating if above minimal qualifications are not met** (i.e., If the specialist in example a did not meet minimal qualifications, her provisional rating of a "4" becomes a "3;" if specialist in example b1 above did not meet minimal qualifications, her provisional "3" rating is reduced to a "2" rating.).

Two Specialists on Team (see Step 2 examples above):

- **Two unqualified staff:** The provisional rating is adjusted down to the next lowest rating if *both* specialists do not meet above minimal qualifications.
- **One qualified and one unqualified staff:** If one specialist meets qualifications, but the other does not, the final rating is the higher of the following two options: a) final rating is based solely on the one qualified staff or, b) final rating based on two unqualified staff (i.e., in example c described above, assume that Specialist 1 (adjusted FTE of 0.60) met qualifications, but Specialist 2 (adjusted FTE of 0.33 FTE) did not. Their aggregate FTE is 0.93 FTE (provisional "4" rating), and would be reduced to a "3" as one specialist does not meet qualifications (option b). Alternatively, we could rate based only on the one qualified staff, Specialist 1 (option a). However, her adjusted FTE of 0.60 only earns a "3" rating on its own. Thus, in this example, both options would result in a "3" rating.

† **Specialist-related activities**: Estimated percent of client contacts that involve any activity associated with the specialty area. Qualifying client contacts include those where engagement practices are delivered while providing other case management

services, as well as more obvious specialty-related interventions or assessments. To get full credit (i.e., to be rated according to actual FTE with the team), *at least 80%* of client contacts should involve a specialty-related activity.

‡**Supporting specialists' estimations:** Evaluators are encouraged to consider other data sources to gauge the approximate amount of time spent in specialist activities. Evaluators should first consider the specialist's estimation, then cross-check that estimation with other data sources, such as activities reported in the daily team meeting, noted in the client log, and progress notes. If a significant discrepancy occurs, evaluators should adjust this percentage, discussing with specialist if possible to agree on a more accurate percentage of time devoted to specialist activities. Otherwise, evaluators should adjust reported percentage, keeping in mind the following heuristic guidelines:

- For a specialist who provides a *high degree* of peer support services (e.g., 80% or more), it is assumed that such a high level of practice will be evident across multiple data sources, reflecting both formal (e.g., WRAP or IMR) and informal wellness interventions—e.g., chart review (majority of notes (at least 60%) written by this specialist indicates some peer support service), observation of daily team meeting (i.e., reported contacts involving WMR and peer support services, and scheduled contacts to address client's WMR needs), and a large breadth of peer support and WMR services being provided. Although informal WMR services can be easily bundled with many case management tasks, including medication deliveries, the expectation is that there are many strategic opportunities for WMR services not attached to such activities.
- For a specialist who provides a *moderate degree* of peer support services (e.g., 40% - 60%), it is assumed that a moderate level of practice will be evident across several data sources—e.g., chart review (some notes (e.g., 20% - 60%) written by this specialist indicates peer support service), observation of daily team meeting (i.e., reported contacts involving peer support services, and scheduled contacts to address client's WMR needs), the breadth of peer support and WMR services being provided may vary.
- For a specialist who provides a *low degree* of peer support services (e.g., 10% - 30%), it is assumed that there will be little evidence of such practice when reviewing multiple data sources—e.g., chart review (very few notes (< 20%) written by this specialist indicates some peer support service), observation of daily team meeting (i.e., very minimal mention of peer support and WMR services, if at all), and peer support services themselves may be lacking or very limited (e.g., majority of peer support services consists of discussions about symptom management). Peer Specialists used primarily to do wellness or symptom checks, medication deliveries, and/or transportation are not to be credited highly if this is the only time they are reporting any WMR interventions.

	1	2	3	4	5
ST7. Peer Specialist on Team	Less than 0.25 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE peer specialist with at least minimal qualifications.

NOTE: If there is no peer specialist on the team, rate this item as a "1," but do not rate ST8 as long as peer specialist vacancy has been less than 6 months. Also, rate peer support specialists hired within past two months on this item, which will likely be a low rating, but do not rate on ST8. If hired more than two months before review, rate new specialist on ST8 as well.

ST8. Role of Peer Specialist

Definition: The peer specialist performs the following functions:
(1) Coaching and consultation to clients to promote recovery and self-direction (e.g., preparation for role in treatment planning meetings);
(2) Facilitating wellness management and recovery strategies (e.g., Wellness Recovery Action Plans (WRAP), Illness Management and Recovery (IMR), or other deliberate wellness strategies);
(3) Participating in all team activities (e.g., treatment planning, chart notes) equivalent to fellow team members;
(4) Modeling skills for and providing consultation to fellow team members; and
(5) Providing cross-training to other team members in recovery principles and strategies.

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

DATA SOURCES (* Denotes primary data source)

Team Survey

Review team's response to item #13 regarding whether the peer specialist facilitates any groups.

Excel spreadsheet (column K)

Examine whether and how many clients receive manualized WMR services directly from the ACT team, and the type of service(s) provided. Use this information to guide interview questions below.

Daily Team Meeting

Observe whether and how the peer specialist contributes to discussions related to WMR services and principles during the daily team meeting. Do they appear to be referred to within the team for guidance and/or consultation?

Team Leader Interview

Are there activities or services the peer specialist is not allowed to do that most other team members are engaging in? *Can they access client records, contribute to treatment planning and assessment, document contacts in progress notes?* [Query for whether the peer specialist can serve as the primary care coordinator for clients —if not, is the reason applicable to qualifications that apply to other non-peer staff (e.g., minimal educational qualifications)?]	
Describe the variety of services provided by the peer specialist. [Prompt for roles described above.]	

Peer Specialist Interview*	
How would you describe your relationship with the individuals served by the ACT team—how do you view them and how do you think they view you?	
What kind of services do you provide to clients? [Use their response to guide whether/how to ask any of the following questions. Refer to Functions #1 and #2 (esp. informal WMR) in Table 21. Also note whether any specific groups facilitated by the peer specialist are listed in the team's response to item #13 in the Team Survey.]	
Can you tell us more about any wellness management and recovery services you provide to clients *[prompt for WRAP, IMR, or any other manualized approach]****? In what ways do you use*** [insert whatever formal, manualized, WMR they reported using]***? How often do you provide these services?***	
Are you familiar with what a psychiatric advanced directive is? Have you assisted clients in completing a psychiatric advanced directive? [Prompt for examples.]	
What do you think is the most important function of your role as the peer specialist? [Prompt for whether and how a recovery philosophy is steering the peer specialist's practice in how they work with clients.]	
To what extent have you helped clients understand their own role in their treatment or prepare for their treatment planning meetings?	

Have you worked with someone who was not interested in taking some or all of their medications? Can you describe for me the types of conversations you've had with them about these decisions [or what types of conversations you imagine having if you have not yet such clients]**?**	
Do you feel like you are treated as an equal professional on the team? Are there some things that you are not able to do because of your position? Is your opinion valued as much as other team members? [if no, ask for examples]	
Do you ever provide formal training to other team members? [If yes:] ***When and what kinds of topics do you cover?***	
Do you ever provide consultation to other team members to help them to better understand your role or the services you provide? Or to help them to also learn to provide some of those services themselves? [Prompt for examples where the peer specialist may have advocated for a client, even if in opposition to team members.]	
If we have not yet heard of it yet, can you share with us an example of your practice that you think best reflects your work as the team's peer specialist? [With this example, try to clarify how far back the example dates.]	
What parts of your role do you find to be challenging to fulfill or carry out day-to-day?	
What areas of education or training do you think would be helpful for you to do an even better job in your role?	

Clinician Interview	
How has your work with clients been influenced by the peer specialist? Do you view the peer specialist as a resource? ***Has the peer specialist shared any aspects of their own personal recovery story?***	
Client Interview	
Do you know who the team peer specialist is—*[Insert the name of the peer specialist if no one knows]****? How often do you see the team peer specialist?*** ***What kinds of things do you talk about with the peer specialist? How have they helped you?*** ***Do you have a relapse prevention plan? Did anyone help you create this plan?***	

ITEM RESPONSE CODING:

General Frequency Guidelines

- **Cross-training:** Includes formal training (e.g., didactic, skill-based teaching) to other team members at least 20 minutes in duration provided at least one time in the past 6 months.
- **Modeling and Consultation**: Modeling includes demonstration of behaviors and attitudes consistent with a recovery-oriented, wellness management approach to service delivery. Such modeling may occur meetings or in the field. Consultation includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation). To receive credit for Modeling and Consultation, the peer specialist must clearly embrace and model a recovery philosophy.

Rating Guidelines

Use Table 21 below to guide ratings. Use peer specialist interview as primary data source, with client interviews and chart reviews to back-up conclusions. If the peer specialist fulfills all four functions within the team, rate as a "5." Cross-training should be provided within the past 6 months.

"N/A" Criteria: If no person is hired into the peer support specialist position at the time of the review (thereby receiving a "1" rating on ST7) or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

Table 21. Role of Peer Specialist			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Coaching and consultation to clients to promote recovery, self-direction, and independence	There is no evidence that the peer specialist provides any coaching or consultation to clients to promote recovery and self-direction.	The peer specialist provides some coaching and consultation to clients to promote recovery and self-direction, but it is less consistently provided.	The peer specialist consistently works with ACT clients by assisting them with building skills that help promote their own recovery and self-sufficiency. Examples include but are not limited to: • Providing education to clients about how to take an active role in their own treatment and treatment planning; • Teaching self-advocacy skills, including how to assert preferences and values with team, family, and others (e.g., not wanting to take select medications); • Providing coaching regarding independent living skills (e.g., ADLs), safety planning, transportation planning/navigation skill-building, money management).
Function #2: Facilitating WMR strategies	There is no evidence that the peer specialist is facilitating any specific wellness management strategies with clients served on the team.	The peer specialist provides some WMR services, but it is limited (e.g., they are only working with a few clients on WRAP or IMR or provide fewer informal WMR strategies than are listed in the next column for full credit). The peer specialist may be accessing manualized WMR material, but in a very informal and inconsistent manner (note: targeted use of IMR is an acceptable use of this evidence-based practice, where carefully selected modules are focused on for a given client).	The peer specialist takes a lead role within the team on implementing WMR strategies. These can be formal/manualized or informal strategies: **Formal/Manualized:** • Group or individual IMR; • Group or individual WRAP; • Facilitating Psychiatric Advance Directives **Informal:** Working with clients on all of the following: • Providing targeted psychoeducation about mental illness and medications; • Identifying early warning signs for relapse and lapses; • Identifying triggers for relapses and lapses; and • Developing a relapse prevention plan.

Table 21. Role of Peer Specialist			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #3: Participating in all team activities equivalent to fellow team members	There is evidence that the peer specialist does not fully participate in all team activities as is consistent with other team members. There may be one or more limitations and the peer specialist does not appear to be treated as an equal among other staff.	There is one limitation in the role of the peer specialist as compared to other team members, but the peer specialist appears to be treated as an equal among other professionals, per observations and interviews.	The peer specialist is treated just like other team members and fully and actively participates in all team activities such as: • Daily team meetings; • Treatment planning meetings; • Documentation within clients' charts; • Community-based contacts with clients; • Assignment as a "primary" for various interventions indicated within the treatment plan given that applicable qualifications are met to assume such a role; In some states or agencies, peer specialists do not provide crisis coverage, which would be an acceptable exception. Further, any exclusion from team activities is due to qualifications that go beyond the peer status alone.
Function #4: Modeling skills for and providing consultation to fellow team members	The peer specialist does not provide modeling or consultation to other team members.	The peer specialist provides modeling and consultation to other team members but it is either inconsistently provided or inconsistently reported by other team members OR The peer specialist provides either modeling or consultation, but not both.	The peer specialist regularly provides modeling and consultation, as consistently reported by other team members as well as the peer specialist. Modeling and consultation must reflect a recovery philosophy. **Modeling** includes demonstration of behaviors and attitudes consistent with recovery-oriented and WMR services in the daily team meeting and other meetings or in the field. To get full credit, other team members are influenced by the peer's words and actions. **Consultation** includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation) provided at least monthly within the past six months. To get full credit, others see the peer as a helpful resource and seek the peer out for information and guidance.
Function #5: Providing cross-training to other team members in recovery principles and strategies	Peer specialist does not provide cross-training or has not within the past six months.	Peer specialist has provided some cross-training, but it has only been to a few team members or less than 20 minutes in duration in the past six months.	Peer specialist consistently provides cross-training in recovery principles and strategies. **Cross-training** includes formal training (e.g., didactic, skill-based teaching) to other team members at least 20 minutes in duration provided at least one time in the past 6 months.

	1	2	3	4	5
ST8. Role of Peer Specialist	The peer specialist performs 1 or fewer functions on the team.	2 functions are FULLY performed (3 are absent) OR 2 to 3 functions performed, 1 to 2 PARTIALLY.	3 functions are FULLY performed (2 are absent or PARTIAL) OR 4 to 5 functions PARTIALLY.	4 functions are FULLY performed (1 is absent or PARTIAL).	ALL 5 functions are FULLY performed.

CP1. Community-Based Services

Definition: The team works to monitor status and develop skills in the community, rather than in-office. The team is oriented to bringing services to the client, who, for various reasons, has not effectively been served by office-based treatment.

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, the clinician can conduct a more accurate assessment of his or her community setting as 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.

DATA SOURCES (* Denotes primary data source)

Chart Review* - Chart Review Log Part I (p. 195-196) and Chart Review Tally Sheet Part I (p.197-198)

Calculate the ratio of face-to-face community-based contacts to the total number of face-to-face contacts across the randomly selected charts reviewed. Then determine the median proportion of community-based contacts across the sample (e.g., in a 10-chart sample, this would be the average of the 5th and 6th values when the percentage of contacts in the community are rank-ordered). Remember to use the most complete and up-to-date time period from the chart within a four-week (i.e., 28-day) calendar period. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation.

ITEM RESPONSE CODING

Rating Guidelines

Exclude charts with no contacts in that four-week period from the final tally. In scoring this item, only count face-to-face contacts with clients. Do not count phone calls and do not count contacts with collaterals or family members. Use chart review as the primary data source. Evaluator may judge whether select contacts should be included given the meaningfulness of contacts; e.g., a team leader documents a contact that appears to be an unplanned run-in at the agency, with no apparent purpose. If the information from different sources is inconsistent, ask the team leader to help you understand the discrepancy. If at least 75% of total service time occurs in the community, the item is coded as a "5."

For the current purpose of this rating, contacts in institutions (hospital, jails, assisted living facilities) will be treated as community contacts. However, this information may be used to guide qualitative feedback (e.g., a high percent of "community" based contacts that are in residential institutions may suggest a departure from the intent of ACT to focus efforts on helping people live and succeed in more integrated, community-based settings.

Exclude charts with no contacts in that four-week period from the final tally

Formula

Use the Chart Review Tally Sheet or TMACT Calculation Workbook to enter and compute these data.

	1	2	3	4	5
CP1. Community-Based Services	Less than 40% of face-to-face contacts in community.	40 - 54%	55 - 64%	65 - 74%	At least 75% of total face-to-face contacts in community.

CP2. Assertive Engagement Mechanisms

Definition: The team uses an array of techniques to engage difficult-to-treat clients. These techniques include the following:
(1) Collaborative, motivational interventions to engage clients and build intrinsic motivation for receiving services from the team, and, where necessary; and
(2) Therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to client or others.

When therapeutic limit-setting interventions are used, there is a focus on instilling autonomy as quickly as possible. In addition to being proficient in a range of engagement interventions, (3) the team has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of chosen techniques, and modifying approach when indicated.

Rationale: Unlike some community-based programs, ACT clients are not discharged from the program due to failure to keep appointments or not participating in treatment, even if present. 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. Therapeutic limit-setting interventions may be necessary during initial engagement if collaborative interventions fail and risks are too high. When used, therapeutic limit-setting interventions are eventually titrated down to more collaborative interventions to promote empowerment and autonomy.

DATA SOURCES (* Denotes primary data source)

Excel spreadsheet (columns R, S, T, and U)

Examine whether any clients have housing leases specifying that treatment participation is a condition of their housing. How many clients are on involuntary outpatient commitment and/or conditional release? How many clients have a representative payee? How many of those payeeships are held by the team/agency, and to what extent is money managed? How many clients have a guardian? Use this information, which primarily reflects potential therapeutic limit-setting, to guide interview questions below.

Team Leader Interview*

For this item, it is particularly useful to have reviewed charts and observed practice before interviewing staff about the use of assertive engagement. Interview questions listed below are a general guide to getting at some of the information needed to rate this item. However, interview questions are ideally directed by specific examples of clients noted to have received (or not, but clearly needed) assertive engagement practices. Therefore, we recommend readdressing this question with team leader, and other staff, near the end of the evaluation.

How does the team try to keep clients involved in ACT when it is clear that they need ACT services, but are either actively or passively refusing these services? [The focus of interview questions should remain on the team's work with clients who clearly needed ACT, but with whom the team has or had difficulty either physically accessing or interpersonally engaging. Do not focus on clients who are challenging to work with, but are electing to participate in services.]	

Think of 2-3 clients [Or offer examples, as identified through the course of the evaluation] ***who have been hard to engage in the past 6 months. Describe the team's engagement efforts with each of these clients.*** [Engagement refers to the process of having access to a client to determine service needs and wants, and develop a relationship that will encourage service delivery. It includes clients who do not make themselves physically available for contacts, as well as those who are physically available, but unwilling to participate in meaningful service activities.]	
What other techniques does the team use to reach out to clients? [Look for language that suggests motivational. It is important to give team leader an opportunity to offer a range of techniques.]	
[If no therapeutic limit-setting techniques are offered on his or her own, consider following-up with:] ***What is the team willing to try out when these more motivational and softer approaches are not working —the person remains poorly engaged and your concerns for safety and risks remain or our increasing? What then is the team willing to do to engage such clients to keep them in ACT services?*** [Cross-reference with responses to column S in the Excel spreadsheet regarding the number of clients on involuntary outpatient commitment or conditional release. Prompt if there are discrepancies.]	

Do you have a method for identifying and tracking clients in a tenuous engagement phase —how is this done? What do you do with such information? ***How do you identify clients in need of a different engagement tactic than the one the team has been using?*** [Attend to the extent to which the team has a reliable process in place that allows for timely modification of the assertive engagement strategy—e.g., changing up to a new motivational strategy when previous one is failing; moving from a motivational strategy to a more therapeutic limit-setting strategy when risks are increasing; moving from a therapeutic limit-setting to a less restrictive, more motivational approach to help preserve client autonomy.]	
Clinician Interview	
How has your team successfully and/or attempted to engage individuals who clearly needed ACT, but were not wanting ACT services? ***What considerations did the team have when working with these clients?*** *How has the team attempted to engage the client into services to better assure positive outcomes and reduce the chance of harmful effects of lack of treatment? What techniques does the team use to reach out to clients? Can you think of a person the team debated as to how to best engage them in service—and what ideas were put forth by the team?* [Look for language that suggests MI or therapeutic limit-setting techniques and follow-up with additional questions as needed. Try to anchor conversation in specific examples. It is important to give them an opportunity to offer a range of techniques.]	

[If no therapeutic limit-setting techniques are offered on their own, consider following-up with:] ***What is the team willing to try out when these more motivational and softer approaches are not working —the person remains poorly engaged and your concerns for safety and risks remain or our increasing? What then is the team willing to do to engage such clients?***	
Daily Team Meeting	
Listen for clients reported on who appear to be difficult to engage. Does the team set aside time to plan for how to work with these clients, either very briefly during the meeting or by scheduling a follow-up meeting with other team members? Does the team tend to automatically fall back on controlling methods (e.g., outpatient commitment, payee arrangements) in planning how to engage clients? Is there a spirit of creativity and planning around clients who appear to be disengaged?	

ITEM RESPONSE CODING

Rating Guidelines

(1) **Motivational interventions:** A collaborative and non-confrontational approach is the hallmark of MI interventions used to engage clients. The aim is to enhance clients' intrinsic motivation for accessing services from the team. The focus of these interventions is figuring out what is important to the client, what it is that they need/want, and offer assistance in meeting those needs/wants. By getting a foot in the door, so to speak, the ACT team can then work on building rapport and using more MI interventions, such as acknowledging a client's ambivalence around receiving services and expressing empathy and developing discrepancy between a client's expressed goals and current behavior. As motivational interventions should seek to tap something individual about that client, they are often creative. For the sake of rating teams on this item, creative use of inducements (behavioral modification using a reward system) may qualify as a motivational intervention.

(2) **Therapeutic limit-setting:** Therapeutic limit-setting interventions are influencing tactics used to ensure that treatment needs are met in the least restrictive setting and while risk of harm to self or others is minimized. These interventions, which aim to create extrinsic motivation to access services, may limit or threaten to limit a client's self-determination in various life areas (e.g., interpersonal pressures may be used to increase medication adherence, access to money or housing may be leveraged against treatment participation, involuntary commitment to treatment may be sought if client meets local judicial criteria). When motivational interventions have not worked and/or safety concerns do not permit extensive trials of motivational interventions, therapeutic limit-setting interventions may need to be employed.

(3) **Thoughtful application and withdrawal of engagement practices:** The team has a process for detecting when they may need to try a different approach due to client's poor response to engagement tactics. This process may be most evident in the daily team meeting where services are tracked. One intent of this item is to determine *how* the team identifies *when* their engagement strategies are not effective and therefore in need of revision (e.g., if a team continues to attempt to meet with a client at his home for two weeks without success, at what point does the team revise their approach given the lack of success?). Credit for this practice is needed to rate a "5."

Use the team leader interview as the primary data source. Corroborate with observations made during the daily team meeting, chart reviews, and other identified data sources.

Refer to Table 22 below to determine if no, partial, or full credit is met for each criterion. If the team is skilled at employing motivational and collaborative interventions to engage clients, but uses therapeutic limit-setting interventions where necessary, AND is thoughtful about when to apply and withdraw these techniques, the item is coded as a "5."

Exclusive use of Motivational (Practice #1) or Therapeutic limit-setting (Practice #2) interventions (Rating of "2"). Teams that employ therapeutic limit-setting interventions with difficult-to-engage clients (meeting either Full or Partial criteria) with few clear and convincing examples of motivational interventions will likely leave the impression of a highly custodial, paternalistic, and/or coercive team. Although their practices are driven by concern for the client, they tend to heavily rely on strategies that force the client to accept services and prefer to avoid perceived risks that may accompany the use of motivational interventions. Alternatively, teams that employ only motivational interventions (Full or Partial criteria) with no to very few clear and convincing examples of therapeutic limit-setting strategies may leave the impression of a clinically negligent team. The team's concern for undermining client's autonomy and risking damage to the therapeutic relationship consistently overrides the decision to use leverages to help the client avoid further harm. Because teams who are exceptionally skillful in their use of motivational interventions (clear full credit for #1) also may have less need for therapeutic limit-setting; be sure to fully explore what the team is prepared to do in their use of therapeutic limit-setting (i.e., thereby rating higher on this item).

Table 22. Assertive Engagement Mechanisms			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Practice #1: motivational interventions	Motivational interventions are very rarely or not used to engage clients. Examples were few, lacking detail and/or creativity, and situations that would likely benefit from such interventions were observed in the data.	Team uses motivational interventions with the aim of engaging clients who need ACT services, but are passively or actively refusing services, in a limited manner. One or two strategies or techniques were provided (e.g., taking clients out to coffee or lunch, and changing up who saw the client), and/or missed opportunities for such engagement were observed.	Team clearly uses an array of motivational interventions to work with clients who are difficult to engage. There are several robust examples reflecting collaborative and creative approaches to engage client in maintaining contact with the team to receive services. Examples must represent more than two strategies or techniques and go beyond less creative efforts, such as changing up staff who attempt to meet with the client. The following are some descriptive examples of motivational interventions used to engage clients: • persistent, patient efforts to meet with a paranoid and socially anxious woman who refused to speak face-to-face with staff. This included showing up at her apartment at regular times several days a week to offer services, such as running needed errands, and offering to take her out to a local knitting circle since she previously indicated that she liked to knit; • assisting a recently evicted man to find and move to a new residence, while using the increased contact time to discuss how his not taking medications may have created some of the problems leading to eviction; • to develop trust and assess for safety, bringing food to a recently enrolled woman who is staying at the shelter and continuing to prostitute for drugs.
Practice #2: therapeutic limit-setting	Therapeutic limit-setting interventions are very rarely or not used to engage clients. Examples were few, lacking detail and/or creativity, and situations that would likely benefit from such interventions were observed in the data.	Team uses therapeutic limit-setting with the aim of engaging clients who need ACT services, but are passively or actively refusing services, in a limited manner. One or two strategies or techniques (e.g., using representative payee role to leverage treatment participation) were provided, and/or missed opportunities for such engagement were observed. *Note: A team may be extremely adept at using more motivational interventions to engage clients and very rarely need to resort to therapeutic limit-setting, therefore	Team clearly uses an array of therapeutic limit-setting interventions to work with clients who are difficult to engage, or is willing to use an array of techniques if skillful at Practice #1. Evaluators observed robust examples of the team maximizing clients' extrinsic motivation to maintain contact with the team to receive services. Examples must represent more than two strategies or techniques. The following are some descriptive examples of therapeutic limit-setting interventions used to engage clients: • coordinating closely with a disengaged and decompensating client's representative payee to associate timing of more frequent disbursements with team contact for the purpose of increased contact; • working closely with a client's probation officer to arrange for a supervised living residence with stipulations around abstinence and medication adherence; • petitioning for involuntary inpatient commitment of a female client who, after months of living in a shelter and prostituting for drugs during an emerging manic episode, increasingly puts her

Table 22. Assertive Engagement Mechanisms			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
		having few examples to provide. Such a team may get full credit as long as data suggest that the team is willing and able to employ these more restrictive tactics, when needed.	safety at risk and is unresponsive to team's engagement efforts to offer to move to more stable housing—upon hospital discharge, team assisted in her moving into a temporary supervised apartment while she remained on a conditional release.
Practice #3: thoughtful application and withdrawal of engagement practices (Relevant for differen-tiating "4" and "5" ratings)	There is no clear and systematic process being used for tracking the need for and success of team's engagement efforts, ultimately steering team's engagement efforts. Teams who are negligent of this identification process and/or who are not proficient in engagement tactics, may have a higher drop out rate (see item OS10).	No partial credit option.	Team leader was able to clearly articulate a process for tracking the team's engagement efforts, such as by periodically reviewing the daily log and meeting as an ITT to review strategies, response, and plan for new engagement approaches. For example, team leader provided a specific example of how this process resulted in a modification of the team's approach to working with a woman residing in a shelter who was not responding to motivational interventions and required a more deliberate and forceful approach to ensure safety. *Note: A team's management of a "high-risk" or "watch-list" does not on its own earn full credit for this practice. Such a list must clearly be operational in guiding what the team is doing as it relates to assertive engagement.

	1	**2**	**3**	**4**	**5**
CP2. Assertive Engagement Mechanisms	Very little assertive engagement is evident (#1 and #2 are largely absent).	Team primarily relies on #1 OR #2, not both (1 approach is FULLY or PARTIALLY used and 1 is not used at all (No Credit)).	A more limited array of assertive engagement strategies is used (PARTIAL #1 and #2).	Team uses #1 and #2 (at least 1 approach is FULLY used). Thoughtful application/ withdrawal of engagement strategies is significantly lacking or absent (#3 is absent).	Team is proficient in assertive engagement strategies, including thoughtful application/ withdrawal of engagement strategies, applying all 3 practices.

CP3. Intensity of Service

Definition: The team delivers a high amount of face-to-face service time as needed.

Rationale: To help clients with severe and persistent symptoms maintain and improve their functioning within the community, addressing a broad range of life goals and providing extensive therapeutic and rehabilitative interventions, a high service intensity is often required.

DATA SOURCES (* Denotes primary data source)

Chart Review* - Chart Review Log Part I (p. 195-196) and Chart Review Tally Sheet Part I (p.197-198)

Use the same charts as used for Item CP1. 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. Teams are queried whether they have their own scaling system used internally, which can guide random chart selection) From the mean values over a four-week period, determine the median number of service hours across the sample (e.g., in a one chart sample, this would be the average of the 5th and 6th values when the mean service hours per week are rank-ordered). Remember to use the most complete and up-to-date time period from the chart during a recent four-week (i.e., 28 day) time frame. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation. See TMACT Part I for guidance in how to use a complete client population data from an electronic medical record query.

ITEM RESPONSE CODING

Rating Guidelines

- In scoring this item, only count face-to-face contacts with clients. Do not count phone calls and do not count contacts with collaterals or family members.
- The evaluator may judge whether select contacts should be included at all in the chart tally given the quality of contacts (e.g., a team leader documents a contact that appears to be an unplanned run-in at the agency, with no apparent purpose).
- As this rating can be inflated by overuse of practices that deviate from more person-centered care (e.g., high use of office-based recreational groups), rate according to the data and consider providing qualitative feedback.
- Clients who receive extensive monitoring at the clinic because of a long-acting injection (e.g., Zyprexa Relprevv) should not be credited for the 180 minutes of monitoring time unless that time includes delivering of other services beyond passive and period monitoring. It is suggested that 60 minutes are credited when no other clear services are provided during this monitoring period.
- If the team does not separate out travel time (without client present) from service contact time, you should not rate this item, excluding it from the final TMACT ratings.

Use chart review as the primary data source. If the information from various sources is inconsistent, ask the team leader to help you understand the discrepancy.

Formula

Use the Chart Review Tally Sheet or TMACT Calculation Workbook to enter and compute these data.

	1	2	3	4	5
CP3. Intensity of Service	Average of less than 15 min/week or less of face-to-face contact per client.	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 client.

CP4. Frequency of Contact

Definition: The team delivers a high number of face-to-face service contacts, as needed.

Rationale: ACT clients require more intensive follow-up and ACT teams are to be the sole provider of a range of biopsychosocial services. ACT teams are highly invested and maintain frequent contact to provide ongoing, responsive support as needed. Frequent contacts are associated with improved client outcomes.

DATA SOURCES (* Denotes primary data source)

Chart Review* - Chart Review Log Part I (p. 195-196) and Chart Review Tally Sheet Part I (p.197-198)

Use the same charts as used for Item CP3. Calculate the mean number of face-to-face client-ACT service contacts, per week, over a month-long period. From the calculated mean values, determine the median number of service contacts across the sample (e.g., in a 10-chart sample, this would be the average of the 5th and 6th values when the mean service contacts per week are rank-ordered). Remember to use the most complete and up-to-date period during a recent 4-week time frame. Ask the team leader, clinicians, or an administrative person for the most recent and complete period of documentation.

Team Leader Interview

How many clients are scheduled to be seen four or more times a week?	
What are some of the reasons for such high number of visits?	
Who is seen least often, per the schedule? [Further query for the number of clients who are scheduled to be seen less than once per week and the reasons for this level of care. This information can help provide context for what is observed in the chart review, especially as to the flexibility of services in general and the reason for the level of care provided. Such information may be used in qualitative feedback.]	

ITEM RESPONSE CODING
Rating Guidelines
• Only count face-to-face contacts with clients. Do not count phone calls or contacts with collaterals or family members. • If a client receives several consecutive contacts across staff, judge whether these contacts are meaningfully differentiated. If they are not, count a series of consecutive contacts in one day with multiple staff as one contact for that day. • The evaluator may judge whether select contacts should be included at all in the chart tally given the quality of contacts (e.g., a team leader documents a contact that appears to be an unplanned run-in at the agency, with no apparent purpose). • Attend to high frequency contacts that detract from person-centered, recovery-oriented services (e.g., clients receiving frequent contacts centered solely on medication and money management services). Although we do not recommend adjusting the rating and continuing to rate given the data, we do recommend providing qualitative feedback. Use chart review as the primary data source. If the information from different sources is inconsistent, ask the team leader to help you understand the discrepancy.
Formula
Use the Chart Review Tally Sheet or TMACT Calculation Workbook to enter and compute these data.

	1	2	3	4	5
CP4. Frequency of Contact	Average of less than 0.5 face-to-face contact / week or fewer per client.	0.6 - 1.3 / week.	1.4 - 2.1 / week.	2.2 - 2.9 / week.	Average of 3 or more face-to-face contacts / week per client.

CP5. Frequency of Contact with Natural Supports

Definition: The team has access to clients' natural supports. These supports either already existed, and/or resulted from the team's efforts to help clients develop natural supports. Natural supports include people in the client's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy).

Rationale: Developing and maintaining community support further enhances client's community integration and Many studies have found that other evidence-based practices are enhanced when the family and other natural supports are involved in treatment.

DATA SOURCES (* Denotes primary data source)

Excel spreadsheet (column X)*

Review for number of contacts with clients' natural supports.

Team Leader Interview

Refer to Excel spreadsheet (column X): ***In looking at your team's contact with clients' natural supports, I just need to confirm that these do NOT include contacts with paid service providers*** (e.g., primary care physicians, parole officers, and employed payees). Some discretion may be used here, such as a primary care physician may be truly operating as a natural support to the client.	

ITEM RESPONSE CODING

Rating Guidelines

Use Excel spreadsheet as primary data source. Include **all contacts** (i.e., face-to-face, telephone, and email) with family, friends, landlord, and employer; exclude persons who are paid to provide assistance to the client, such as Social Security Disability or Department of Human Services representatives. Tabulate the percent of clients who the team reports at least once a month contact with natural support system. If the reported number is high (at least 76%), seek corroboration from other sources, including some evidence in chart documentation.

	1	2	3	4	5
CP5. Frequency of Contact with Natural Supports	For less than 25% of clients, the natural support system is contacted by team at least 1 time per month.	26% - 50%	51% - 75%	76% -89%	For at least 90% of clients, the natural support system is contacted by team at least 1 time per month.

CP6. Responsibility for Crisis Services

Definition: The team has 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria: (1) The team is available to clients in crisis 24 hours a day, seven days a week; (2) The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging); (3) The team accesses practical, individualized crisis plans to help them address crises for each client; and (4) The team is able and willing to respond to crises in person, when needed.

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, which should be informed by previous crisis planning with ACT clients, continuity of care is maintained.

DATA SOURCES (* denotes primary data source)

Chart Review - Chart Review Log Part II (p. 197-198) and Chart Review Tally Sheet Part II (p.201-202)

A crisis plan is considered "practical" if it is individualized (i.e., reflecting the client's unique circumstances and preferences) and provides the necessary information to guide how to best respond to the client when they are in a crisis.

Team Leader Interview*

What is the ACT team's role in providing 24-hour crisis services? *How is the ACT team involved in crisis assessment and response during after-hours and on weekends?*	
Do calls come in directly to the on-call staff? [If not, clarify who receives calls and level of triaging, about what percent of calls are connected to the ACT on-call staff.]	
In what ways does the on-call staff have access to crisis plans? Can you give an example of how crisis plans have been useful during a crisis?	
Can you describe the most recent example where on-call staff responded to a crisis during after-hours and/or on weekends?	

Client Interview	
If you find yourself experiencing a crisis, what would you do and who would you reach out to? [Prompt for whether they would access the team, specifically the crisis on-call—do they know the crisis hotline number?]	
What has been your experience with getting help from the team when you were in a crisis? [Did the client find the team to be helpful and accessible?]	
Do you recall creating a plan with the team for how to best help you when you are experiencing a crisis? [If yes:] ***Do you feel like that plan has been helpful?***	

ITEM RESPONSE CODING

Rating Guidelines

Refer to Table 23 to determine if no, partial, or full credit was met for each criterion. Of note, a team that shares responsibility for crisis services across other programs within the agency should be rated lower (e.g., criterion #1 is no credit as there are times non-ACT staff are the on-call; and criterion #2 is likely a no or partial credit as there are times when non-ACT staff are not directly receiving calls, if at all).

Table 23. Responsibility for Crisis Services

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team is available to clients in crisis 24 hours a day, seven days a week	The team is unavailable to clients in crisis at all times (i.e. the team maintains a more limited crisis on-call schedule, such as between four and midnight, or may share this responsibility across other agency programs leaving blocks of time with no ACT team staff as on-call). The team may solely use a third party for receiving all crisis calls.	No partial credit option.	The team is available to clients in crisis at all times, 24 hours a day, seven days a week.

Criterion #2: The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging)	The team is not the first-line crisis evaluator and responder. A third party receives all calls and handles the majority of them. There may be some cases where the team intervenes, but that is more the exception.	A third party (whether internal or external to provider agency) receives all crisis calls and conducts assessment beyond identifying client as an ACT service recipient. The result is that while the ACT team does receive many crisis calls, some do not get patched through to the ACT crisis on-call during after-hours.	When a client calls the crisis line, they either immediately reach the ACT team or are promptly patched through to the ACT team with nearly no screening. Because the ACT team has more assessment and treatment information regarding each client and it is available at all times, it is critical that the team is primarily responsible for determining whether a situation is an actual emergency or not.
Criterion #3: The team accesses practical, individualized crisis plans[8]	Clients do not have practical crisis plans, OR clients do have practical crisis plans, but this information is not accessible to on-call staff person.	Crisis plans existed and were accessible to staff, but lacked the level of information needed to make them useful (e.g., crisis triggers or warning signs, effective coping mechanisms, less restrictive crisis respite options); OR Practical crisis plans existed, but: • Were located in less than 65% of reviewed charts; AND • Crisis plan information was accessible to the on-call staff person.	Crisis plans: • A practical crisis plan (e.g., reflected useful information to address crises for each client) was identified in at least 65% if the reviewed charts; AND • Crisis plan information was accessible to the on-call staff person. • *Note that WRAP, IMR, and psychiatric advance directives may lend to the development of practical crisis plans, which would count here.
Criterion #4: The team is able and willing to respond to crises in person, when needed	The team is unable or unwilling to respond to crises in person. No or very few examples are provided.	The team reports being willing to respond to a crisis call in person during after-hours, but with hesitation. The team provides some examples, but it appears that face-to-face contact is used as an absolute last resort.	In addition to the team responding to client crises via phone, the team assesses the need for whether an in-person contact is needed to either conduct further assessment to determine safety and need for hospitalization or address crisis. In such instances, depending on the situation, the team ideally has a protocol to assure that staff safety is also attended to when in-person response is needed.

	1	2	3	4	5
CP6. Responsibility for Crisis Services	Team has no responsibility for directly handling crises after-hours.	Team meets up to 2 criteria at least PARTIALLY OR criterion #1 is not met.	Team meets criterion #1 and at least PARTIALLY meets 2 to 3 criteria.	Team meets 3 criteria FULLY and 1 PARTIALLY.	Team FULLY meets all 4 criteria.

[8] Use the Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of charts that include a practical crisis plan

CP7. Full Responsibility for Psychiatric Services

Definition: The team assumes responsibility for providing psychiatric services to clients, where there is little need for clients to have to access such services outside of the team. The psychiatric care provider assumes most of the responsibility for psychiatric services. However, the team's role in medication administration and monitoring are also considered in this assessment, especially when evaluating psychiatric services provided to clients residing in supervised settings where non-ACT staff also manage medications; the expectation is that ACT staff play an active role in monitoring medication management even when a client is in a residential setting.

CP8. Full Responsibility for Psychiatric Rehabilitation Services

Definition: These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration). Psychiatric rehabilitation should address functional deficits, environment, as well as the lack of necessary resources, all of which are identified through the assessment process. As such, deliberate and consistent skills training which typically includes staff demonstration, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings. Psychiatric rehabilitation services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, and weekly client schedules).

Rationale for CP7 and CP8: The ACT team is ideally equipped to provide quality services across a range of treatment domains so that clients with relevant needs are well-served and do not have to access these services externally. Creating a one-stop service team should theoretically eliminate communication problems and lead to a more seamless service system working to meet clients' goals. Clients should have the option to receive select services elsewhere, but it is expected that the percentage of clients doing so would be low given that the team is adequately providing the service themselves and meeting clients' needs. Team limitations (e.g., lack of staff to provide service, lack of skills, and lack of time) are not a good reason for clients receiving services externally. The Full Responsibility for Service items (CP7 – CP8) assess the percentage of clients who are receiving a needed service and the extent to which the ACT team is assuming responsibility for delivering this service.

DATA SOURCES (* denotes primary data source)

Data Source	CP7. Psychiatric Services	CP8. Psychiatric Rehabilitation Services
Excel spreadsheet*	columns C and D	columns J and L
Staff Interview*	Nurse	Clinician
Chart review*	Frequency of visits with ACT psychiatric care provider	Rate at which psychiatric rehabilitation services are documented in charts

Refer to other data sources to support service penetration estimates, such as other staff interviews and daily team meeting (e.g., services reported and planned for)

ITEM RESPONSE CODING: Scoring of items CP7 and CP8 is based on the percent of individuals with a given need who are receiving services in that particular service domain from the team. The following equation is calculated for each of the Full Responsibility for Service items (further direction in gathering data for the numerator and denominator will follow):

$$\frac{\textbf{\% of clients receiving service directly from team}}{\textbf{\% of clients needing and/or wanting service (see base rates listed below)}}$$

Calculating the Numerator:

% of clients receiving service directly from team

To determine the numerator, only consider the number of clients receiving services directly from the team. Attend to the definition of the service, as provided to the team in the Excel spreadsheet, the number of clients reported by the team as receiving this service from the team, and other considerations and data sources.

Full Responsibility for Psychiatric Services (CP7) Excel spreadsheet Definition and Instructions:

The team assumes responsibility for providing psychiatric services to clients, where there is little need for clients to have to access such services outside of the team. Core psychiatric services include psychopharmacologic treatment and regular assessment of clients' symptoms & response to medications, including side effects, provided by the team's psychiatric care provider; and medication monitoring and supports provided by other ACT team members. The team's role in medication administration and monitoring are also considered in this assessment, especially when evaluating psychiatric services provided to clients residing in supervised settings where non-ACT staff also manage medications; the expectation is that ACT staff play an active role in monitoring medication management even when a client is in a residential setting.

Worksheet 1. **Calculating the number of clients receiving psychiatric services (CP7) from the team (numerator).**	**Number/ Percent of clients**	
	Team Hope example	**Data Input**
A. How many clients were reported (**Excel spreadsheet, column C**) to be directly receiving psychiatric services from the team? • Engagement-related psychiatric services may also be counted (e.g., if a client is refusing medications, but provider continues to offer other services), but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Clients who are hospitalized and currently under the care of inpatient psychiatric providers can still count toward the numerator if ACT team psychiatric care provider is following client's care and in contact with hospital, and intends continuing treatment upon discharge.	**(A) Team Reports:** 98 clients, per example of Team Hope, are receiving psychiatric services from the team.	
• Be sure to **only include clients seen by psychiatric care providers who met team inclusion criteria** described in CT3 (if the caseload is shared across providers, clients may be counted if a qualifying psychiatric care provider is seeing these clients). Also include clients with contact with psychiatric residents, although the residents themselves are not qualified for CT3.		
As an example, **Team Hope** is serving 100 clients and reported that 98 were receiving psychiatric care provider services from the team, which includes the 0.60 FTE psychiatrist who is considered part of the team, and the 0.20 FTE psychiatric resident, who is not considered part of the team. Two (2) clients are meeting with non-ACT psychiatrists.		
B. Number of clients who are living in residential settings who are *not* directly receiving medication monitoring from the team, or there is poor communication and collaboration between the residential facility and the team regarding medication monitoring, including missed medications, tolerance of side effects, and overall symptom reduction (Refer to column D, see responses from Nurse Interview below, which asks about staff role in	**(B)** 6 clients are in residences with on-site med monitoring and inadequate	

medication monitoring for those clients noted to be living in residential settings). As an example, **Team Hope** reported in column D that 12 clients are in residential settings with medication monitoring services delivered by residential staff. Of those 12, 6 are in a group home where the team has inadequate communication with residential staff, per staff interviews.	coordination/ communicatio n with team about meds.	
C. Approximate percent of all clients who are seen by the psychiatric care provider <u>less often than every 3 months</u>, per chart review. To determine this approximate percent: • If less than 20% of clients had inadequate follow-up (seen less often than 3 months) AND at least 30% were seen within six weeks, do not make adjustments using Step C. • For those client charts where the team was reported to provide psychiatric care services (column C) <u>and who had not been excluded from the count per Steps A and B above</u>, compute the percent of client charts with inadequate follow-up by psychiatric care provider. "Inadequate follow-up" includes those client charts observed with 3+ months between contacts, which includes most recent contact. • **Evaluator discretion is an option** when it comes to counting a client not seen within 3+ months against the provider. In example, clients not seen often with a rationale consistent with best practice (e.g., a client who has been in jail for the previous 4 months, but has been having contact with other team members; two clients who were not seen within 3 months, but had many attempts in the interim, while remaining clients reviewed seen within 6 weeks). As an example, 20 charts from **Team Hope** were reviewed and 5 charts were of clients not seen within 3 months, but reported to be receiving psychiatric care from the team (column C). One of these 5 charts was for a client deducted per Step B above due to residential living with little team oversight. Thus, 4 of 20 charts, or 20%, is calculated to approximate inadequate follow-up. However, in review of overall practice, at least two charts had documented attempts by psychiatric provider to see these clients more often. Evaluators adjusted the percent likely receiving inadequate follow-up to 15%.	**(C)** 15%	
Total number of clients receiving service (numerator): The final calculation for the numerator is as follows with Team Hope example to follow: **[(Step A – ((Step A – Step B) *Step C))/current caseload] * 100 (this is the final step to translate into a percentage)**. For Team Hope, this is [(98 – ((98 – 6) * 0.15)) / current caseload (100)] *100 [(98 – (92 * 0.15)/100)] * 100 [(98 – 13.8)/100] * 100 = [78.2/100] * 100 = 0.78 * 100 = **78%.** Refer to Table 24 for further guidelines on making adjustments.	Estimated percent of clients receiving psychiatric services from the team **(numerator):** 78%	

Nursing Interview	
If the team reports that clients are receiving medication monitoring from non-ACT providers (column D), ask the following: ***Tell me about what happens when clients receive medication monitoring from other providers. How does the team work with these providers— this includes residential staff? If a client wasn't tolerating a particular medication or missed their medication, how would you know*?** [Go through each client noted to be living in residential setting with medication monitoring (column D). If team plays minimal role in medication management oversight for clients in residential setting, do not count these clients toward the numerator value, regardless of the ACT team's psychiatric care provider prescribes the medications for these clients.]	

Full Responsibility for Psychiatric Rehabilitation Services (CP8)
Excel spreadsheet Definition and Instructions:

These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration). Psychiatric rehabilitation should address functional deficits as well as the lack of necessary resources, all of which are identified through the assessment process. As such, deliberate and consistent skills training which typically includes staff demonstration, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings. Psychiatric rehabilitation services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, and weekly client schedules).

To compute the rate at which psychiatric rehabilitation services are provided by the team, first start by examining the rate at which the team reports to be delivering this service themselves (column J). If there is a clear discrepancy between what the team reports and what is observed in the chart data, evaluators are encouraged to adjust the reported percent given the weight of other data sources. We offer two methods below for comparing data sources and determining the most accurate estimate of actual performance. The first method **(Method 1 in Worksheet 2)** compares the team's report with all sampled charts (regardless if those individual charts were of clients to whom the team reported delivering the service); Method 1 can detect potential underreporting by the team in column J, but may be more likely to produce incorrect estimates if the sample is not representative of all clients reported to receive that service. The second method **(Method 2 in Worksheet 3)** examines the presence of psychiatric rehabilitation services only for those clients the team reported affirmatively in column J; Method 2 may be more accurate when the team reported a low penetration rate to begin with (e.g., the team reported less than 20% of clients as receiving the service), as the odds of sampling a representative sample may be compromised, or generally if sample is not representative of what the team reported in service delivery. Method 2 may be more likely to produce incorrect estimates if the timespan of chart review dates considerably predates the time of when the team completed the Excel spreadsheet.

Worksheet 2. Method 1. **Calculating the number of clients receiving psychiatric rehabilitation services (CP8) from the team (numerator).**	**Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving psychiatric rehabilitation from the team? (**Excel spreadsheet, column J**). Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served (or listed in Excel if there is a discrepancy). • Engagement-related rehabilitation services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.	**Team Reports: (A)** 82% are receiving psych rehab services from the team	
Team Hope example. The team reported that 82 of the 100 clients (82%) were receiving psychiatric rehabilitation services from the team.		
B. What percent of all charts reviewed were observed to have any psychiatric rehabilitation service at all (i.e., regardless of it being systematically provided and regardless of quality judged as high or low)? **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 60% found any evidence of psych rehab services	
The results of **Team Hope's** Chart Review found that 12 of 20 (60%) charts were judged to provide some psychiatric rehabilitation, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of psychiatric rehabilitation? (This information may inform how much of an adjustment to make to team's report if there is a discrepancy between their report and chart observation.) • Calculate the percent of charts observed with "high quality" examples of psychiatric rehabilitation (i.e., # of those judged high quality / # judged to have some psychiatric rehab service). • Calculate the percent of charts observed with "systematic delivery" of psychiatric rehabilitation (i.e., # of those judged systematic / # judged to have some psychiatric rehab service). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned psychiatric rehabilitation interventions in person-centered plans and/or client schedules, whether and how clients are using clubhouses and drop-in centers (column L).	**Other Data**: **(C)** 50% "high quality;" 75% "systematic;" and other examples judged to be moderate	
The results of **Team Hope's** Chart Review found that 6 of 12 charts (50%) were judged to be of "high quality," and that 9 of 12 (75%) were systematically delivered. Although planning was lacking in specified interventions and there was limited notation of planned psychiatric rehab interventions in client schedules, several good examples were provided by interviewed staff. Only three clients were accessing local club house or drop-in centers, with no evidence to suggest this was in lieu of the team not providing psychiatric rehabilitation.		
Calculating percent of clients receiving service (numerator): Compare **Steps A (Team Report) with B (Chart Review)**. If there's a significant discrepancy (e.g., a **difference of 20 percentage points or more**) between these two estimates, adjust from the team's report (A) in the direction of data observed (B; chart data). The extent of this adjustment depends on other data sources (see Step C). We		

recommend using either thirds or quarters to adjust team's reported percent (e.g., a discrepancy of 30 points could be divided in thirds (10, 20, 30), and how many "thirds" used to adjust would depend on other data sources (see Step C); clear "moderate" findings may suggest cutting the difference in half. Also, refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. Other Tips: • If team reports that all/nearly all clients are receiving the service, then consider adjusting closer to chart review data as the sample would be representative of reported practice (i.e., by default, it reflects Method 2 described below). • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • Regardless if using Method 1 or 2 to calculate percent receiving psychiatric rehabilitation services, if examples cited are clearly a departure from best practices (e.g., all noted examples were judged to be of "low quality" due to there being a highly directive nature to how psychiatric rehabilitation services were being delivered), consider rating a "1" for this item.	Estimated percent of those receiving psych rehab services from Team Hope **(Numerator)**: 71%	
As an example, there was a discrepancy of 22 percentage points between what **Team Hope** reported (82%) and what was observed in the charts (60%), with other data sources overall suggesting a moderate level of practice. Evaluators chose to cut the difference in half, dividing 22 in half (22/2 = 11) and reducing the team's report by 11 percentage points (82-11 = 71%).		

Worksheet 3. Method 2. **Calculating the percent of clients receiving psychiatric rehabilitation services (CP8) from the team (numerator).**	**Percent of Clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving psychiatric rehabilitation from the team? (**Excel spreadsheet, column J**). Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served. • Engagement-related rehabilitation services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.	**Team Reports: (A)** 82% are receiving psych rehab services from team	
Team Hope example. The team reported that 82 of the 100 clients (82%) were receiving psychiatric rehabilitation services from the team.		
B. What percent of those indicated as receiving psychiatric rehabilitation services from the team (Excel spreadsheet, column J) were found to receiving such services, per the chart review? Refer to the **Chart Review Tally Sheet Part I** (Refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results (B)**: 71% of charts found any psych rehab service	
Team Hope example: In the sample of 20 charts reviewed, 17 clients were reported to be receiving psychiatric rehabilitation from the team, per the Excel spreadsheet (column J). The results of Team Hope's Chart Review found that 12 of 17 (71%) charts were judged to provide some psychiatric rehabilitation, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of psychiatric rehabilitation? (this information may inform how much of an adjustment to make to team's report) • Calculate the percent of charts observed with "high quality" examples of psych rehab (i.e., # of those judged high quality / # judged to have some psychiatric rehab service). • Calculate the percent of charts observed with "systematic delivery" of psych rehabilitation (i.e., # of those judged systematic / # judged to have some psych rehab service). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned psychiatric rehabilitation interventions in person-centered plans and/or client schedules, whether and how clients are using clubhouses and drop-in centers (column L).	**Other Data**: **(C)** 50% "high quality;" 75% "systematic;" and other examples judged to be moderate	
Team Hope's Chart Review found that 6 of 12 charts (50%) were judged to be of "high quality," and that 9 of 12 (75%) were systematically delivered. Although planning was lacking in specified interventions and there was limited notation of planned psychiatric rehab interventions in client schedules, several good examples were provided by interviewed staff. Only two clients were accessing local club house or drop-in centers, and it was not clear it was in lieu of the team not providing psychiatric rehabilitation.		
Calculating percent of clients receiving service (numerator): If the percent found in Step B was at least 90%, then we recommend using the percent the team reported in Step A as the numerator. If the percent found in Step B is lower than 90%, consider adjusting the team's report using these guidelines: If other data sources are moderate to high (Step C), then you will apply the percent found in Step B following these rules: • Take the percent found in Step B and add 10 to it (e.g., 71% + 10 = 81%)		

Why add 10? As we are generalizing the findings from the sample to the total caseload, adding 10 helps reduce potential error if the sample underrepresented the work of the team. When other data sources are generally favorable (Step C), we are more inclined to add in this margin of potential error. • Apply this percent to what the team reported in Step A. For example, 81% is applied to the team's original report of 82%, which is 0.81 X 0.82 = 0.66 (X 100) = 66% If other data sources are low to moderate (Step C), then you will apply the percent found in Step B following these rules: • Take the percent found in Step B and apply this percent to what the team reported in Step A. For example, 71% is applied to the team's original report of 82%, which is 0.71 X 0.82 = 0.58 (X 100) = 58%. • If other data sources (Step C) indicate a lower quality overall, the evaluators have discretion to reduce the percentage in Step B down by 10. As an example, if Step C was judged to be overall low (very few to no examples judged high quality, nearly none systematic, and weak to generic examples provided), then the 71% may be reduced to 61%. The final adjustment then would be 0.61 X 0.82 = 0.50, or 50%. Refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • If there is reason to believe the team underreported their services, consider relying more on Method 1 process. Regardless if using Method 1 or 2 to calculate percent receiving psychiatric rehabilitation services, if examples cited are clearly a departure from best practices (e.g., all noted examples were judged to be of "low quality" due to there being a highly directive nature to how psychiatric rehabilitation services were being delivered), consider rating a "1" for this item.	Estimated percent of those receiving psychiatric services from the team **(Numerator)**: 66%	
For **Team Hope,** 71% of the subsample were found to have documented psychiatric rehabilitation (which his lower than 90% to stay with what team reported in Step A). Other data sources (Step C) were favorable. Evaluators therefore made an adjustment up from 71% to 81%, and applied the 81% to the reported 82% (Step A), resulting an adjusted rate of 66%.		

Clinician Interview	
Does the team use a tool or instrument to assess clients' ADL or "functional" skills? [If yes:] ***Can you tell me more about who completes it and how the information is used?***	

Let's take a look at the Excel spreadsheet and the number of clients who directly receive psychiatric rehabilitation services from the team. Tell me more about what these services include. [Randomly select clients noted as receiving psychiatric rehabilitation services and inquire about what those interventions are, and whether they are likely reflected in the treatment plans; keep in mind the clearly stated definition provided to the team on what counts as rehabilitation interventions. *Note that clients attending clubhouses, drop-in centers, or day treatment programming should also be closely examined when assessing the extent of rehabilitation services offered by the team.] ***If we have not yet heard of it yet, can you share with us an example of your or your team's practice that you think best reflects your team's work in providing psychiatric rehabilitation—where there is a focus on functional skill-building?*** [With this example, try to clarify how far back the example dates.]	

Calculating the Denominator:

% of clients needing and/or wanting service
(see base rates listed below)

To determine the denominator (i.e., those needing/wanting the service), we refer to standardized base rates that are thought to reflect the percentage of ACT clients who would want psychiatric and rehabilitative services, as well as those who may not expressed that they want, but appear to need these services, such as those who would benefit from further engagement in that particular service domain. It is assumed that all ACT clients will need/want psychiatric and rehabilitative services, but a slightly more conservative estimate of 90% is used to calculate need/want to allow for client choice and measurement error.

We estimate ***at least* 90%** of ACT clients will need/want the following services:

- Psychiatric services
- Psychiatric rehabilitation services

Service	Numerator (Method 1)	Numerator (Method 2)	Denominator	Final Calculation (Method 1)	Final Calculation (Method 2)
CP7. Psychiatric services	78%	n/a	90%	87%	n/a
CP8. Psychiatric rehabilitation services	71%	66%	90%	79%	73%

Table 24. A Description of Observed Data Given Actual Service Penetration: A Reference Guide for Evaluators.	
Service penetration level	**Considering the Evidence**
High (75 – 100%) Rating 4 or 5	For a team that provides a high level of service penetration, evidence will be observed across most or all data sources. Of the approximate number of clients expected to want/need that particular service (e.g., 90% of total caseload for psychiatric rehabilitation services), at least 75% of reviewed sampled charts (see Chart Review Tally Sheet - Part I) will have service of interest documented in the progress notes. Service will be commented on during the observation of daily team meeting (i.e., reported contacts involving rehabilitative services, and scheduled contacts to address client's rehabilitation needs). For psychiatric rehabilitation services, a relatively large breadth of rehabilitation services is provided (e.g., social and communication skills training, household management, hygiene skills, safety skills, transportation and navigation skills, and money management). Likewise, it is expected that functional assessments are conducted to help determine impairments. There will be few or no clients participating in other non-ACT psychosocial programs (e.g., clubhouse, day treatment programming). The specification of rehabilitative interventions will likely be very precise and descriptive for a team that has fully embraced this practice.
Moderate (50%) Rating 2 or 3	For a team that provides a moderate level of service penetration, evidence will be observed across several data sources. Of the approximate number of clients expected to want/need that particular service (e.g., 90% of total caseload for psychiatric rehabilitation services), between 40 and 60% of reviewed sampled charts (see Chart Review Tally Sheet - Part I) will have service of interest documented in the progress notes. Service will be commented on during the observation of daily team meeting (i.e., reported contacts involving rehabilitative services, and scheduled contacts to address client's rehabilitation needs), and interview data. The breadth of rehabilitative services provided may be more limited, reflecting a less systematic implementation of psychiatric rehabilitation; functional assessments may not be conducted (i.e., rehabilitation interventions are provided with little systematic assessment of the type and extent of functioning impairment, and related cognitive and psychiatric impairments limiting client's functioning).
Low (20% or less) Rating 1	For a team that provides a low level of service penetration, evidence will be observed across very few data sources—e.g., chart review (no or very few charts have notes that make mention of rehabilitative services), observation of daily team meeting (i.e., no mention of rehabilitative services), and interviews. Rehabilitation services, when observed, lack breadth (e.g., the team mentions assisting a few clients with ADL, such as housekeeping and maintenance). Activities are not systematically delivered or follow from a plan (per the definition provided in Excel spreadsheet).

*Note that these heuristic guidelines are intended to provide examples of observed evidence at three distinct levels of service penetration (high, moderate, and low). For teams providing more intermediate levels (moderate-high or low-moderate), evaluators should take into consideration the overall weight of the evidence, considering the three levels provided here. Data on service penetration summarized in Chart Tally II should be used to support, or adjust (upwards or downwards), the team's reported penetration rate, considering the number of clients assumed to want/need that service; refer to appropriate Worksheet that is included in these rating guidelines.

Example: Calculating Full Responsibility Rates for Psychiatric Services and Psychiatric Rehabilitation Services.		
	CP7.Full Responsibility for Psychiatric Services	**CP8. Full Responsibility for Psychiatric Rehabilitation Services**
Numerator Calculation		
	Team reports on the Excel spreadsheet (column C) that all but 2 of the 88 clients are receiving psychiatric services from the team; two continue to work with a psychiatrist they were with prior to the team. Evaluators considered the 10 clients noted as residing in a supervised setting where medication monitoring is provided (column D of Excel spreadsheet). Information gathered from interviews confirmed that the team plays an active role in coordinating medication monitoring with residential staff (had evidence indicated that the team is relatively unaware of clients' response to medications and adherence with medications, then those clients would be excluded from the count). Evaluators conclude that 86 of the 88 **(98%)** clients are receiving psychiatric care services from team.	Team reports on Excel spreadsheet (column J) that all 75 of 90 **(83%)** clients they serve are receiving psychiatric rehabilitation services from team. Of the 18 charts reviewed, evaluators found that a total of 9 (50%) had any notation of psychiatric rehabilitation interventions, with 6 of these rated as "high quality" and 5 (28% of all charts) noted as being systematically delivered. Clinician examples provided were judged to be of high quality, overall. The team is not conducting functional assessments. Using Method 1 (see Worksheet 2), evaluators moderately reduced the 33 percentage point discrepancy (83% reported—50% observed in charts) by 11 (i.e., cutting in thirds) to produce an adjusted percent of **72%** (i.e., 83 – 11) of those served are receiving psychiatric rehabilitation from the team.
Denominator Calculation		
	The **base rate** of **90%** is used to calculate the denominator for both CP7 and CP8**.**	
Formula and Rating	To determine the percentage of clients who were receiving psychiatric services from the team of those who likely needed such services, evaluators calculated the following: **98%** clients estimated receiving / **90%** estimated to need or want psychiatric services = **109%, which rates a "5" on CP7.**	To determine the percentage of clients who were receiving rehabilitative services from the team of those who likely needed such services, evaluators calculated the following: 72% clients estimated receiving / 90% estimated to need or want rehabilitative services = **80%, which rates a "4" on CP8**.

	1	**2**	**3**	**4**	**5**
CP7 Full Responsibility for Psychiatric Services	Less than 20% of clients in need of psychiatric services are receiving them from the team.	20 - 49% of clients in need of psychiatric services are receiving them from the team.	50 - 74% of clients in need of psychiatric services are receiving them from the team.	75 - 89% of clients in need of psychiatric services are receiving them from the team.	90% or more of clients in need of psychiatric services are receiving them from the team.
CP8 Full Responsibility for Psychiatric Rehabilitation Services	Less than 20% of clients in need of psychiatric rehabilitation services are receiving them from the team.	20 - 49% of clients in need of psychiatric rehabilitation services are receiving them from the team.	50 - 74% of clients in need of psychiatric rehabilitation services are receiving them from the team.	75 - 89% of clients in need of psychiatric rehabilitation services are receiving them from the team.	90% or more of clients in need of psychiatric rehabilitation services are receiving them from the team.

EP1. Full Responsibility for Integrated Treatment for Co-Occurring Disorders (COD)

Definition: The team assumes responsibility for providing integrated treatment for co-occurring disorders (COD) services within the larger framework of integrated treatment for COD, where there is little need for clients to have to access such services outside of the team. Core services include systematic and integrated screening and assessment and interventions tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing) and later stages of change readiness (e.g., CBT, relapse prevention). It is expected that the ACT COD specialist will assume the majority of responsibility for delivering integrated treatment for co-occurring disorders, but ideally other team members also provide some integrated treatment for co-occurring disorders services. Integrated treatment for co-occurring disorders reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).

EP2. Full Responsibility for Employment and Educational (EE) Services

Definition: The team assumes responsibility for providing employment and educational (EE) services to clients, where there is little need for clients to have to access such services outside of the team. Core services include engagement, vocational assessment, job development, job placement (including going back to school, classes), and job coaching & follow-along supports (including supports in academic/school settings). It is expected that the ACT Employment Specialist will assume the majority of responsibility for delivering EE services, but ideally other team members also provide some EE services. Employment and educational services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).

EP3. Full Responsibility for Wellness Management and Recovery (WMR) Services

Definition: The team assumes responsibility for providing wellness management and recovery (WMR) services to clients, where there is little need for clients to have to access such services outside of the team. These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. Examples of such services include the development of Wellness Recovery Action Plans (WRAP) and provision of the Illness Management and Recovery (IMR) curriculum. WMR services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).

Rationale for EP1, EP2, EP3: The ACT team is ideally equipped to provide quality services across a range of service domains so that clients with relevant needs are well-served and do not have to access these services externally. Creating a one-stop service team should theoretically eliminate communication problems and lead to a more seamless service system working to meet clients' goals. Clients should have the option to receive services elsewhere, but it is expected that the percentage of clients doing so would be low given that the team is adequately providing the service themselves and meeting clients' needs. Team limitations (e.g., lack of staff to provide service, lack of skills, and lack of time) are not a good reason for clients receiving services externally.

The Full Responsibility for Service items assess the percentage of clients who are receiving a needed service and the extent to which the ACT team is assuming responsibility for delivering this service.

Data Sources (* denotes primary data source)

Data Source	EP1. Integrated Treatment for COD	EP2. EE services	EP3. WMR Services
Excel spreadsheet*	columns A and B	columns E, F, and L	column K
Staff interview*	Co-Occurring Disorders Specialist	Employment Specialist	Peer Specialist and Clinician
Chart Data*	Rate at which Integrated Treatment of COD services are documented in charts	Rate at which EE services are documented in charts	Rate at which WMR services are documented in charts

Refer to other data sources to support service penetration estimates, such as other staff interviews, chart review, daily team meeting (e.g., services reported and planned for).*

ITEM RESPONSE CODING: Scoring of items EP1—EP3 is based on the percentage of individuals with a given need who are receiving adequate services in that particular service domain from the team. Thus, the following equation is calculated for each of the Full Responsibility for Service items (further direction in gathering data for the numerator and denominator will follow):

$$\frac{\text{\% of clients receiving service directly from team}}{\text{\% of clients needing and/or wanting service (see base rates listed below)}}$$

Calculating the Numerator:

$$\frac{\text{\% of clients receiving service directly from team}}{\quad}$$

For the purpose of determining the numerator, only consider the number of clients receiving services directly from the team. Attend to the definition of the service, as provided to the team in the Excel spreadsheet, the number of clients reported by the team as receiving this service from the team, and other considerations and data sources.

To compute the rate at which the service of interest is provided by the team, first start by examining the rate at which the team reports to be delivering this service themselves (Excel spreadsheet). If there is a clear discrepancy between what the team reports and what is observed in the chart data, evaluators are encouraged to adjust the reported percent given the weight of other data sources. We offer two methods below for comparing data sources and determining the most accurate estimate of actual performance. The first method **(Method 1 in Worksheet 2)** compares the team's report with all sampled charts (regardless if those individual charts were of clients the team reported delivering the service to); Method 1 can detect potential underreporting by the team in Excel spreadsheet, but may be more likely to produce incorrect estimates if the sample is not representative of all clients reported to receive that service. The second method **(Method 2 in Worksheet 3)** examines the presence of this service only for those clients the team reported affirmatively in Excel spreadsheet; Method 2 may be more accurate when the team reported a low penetration rate to begin with (e.g., the team reported less than 20% of clients as receiving the service), as the odds of sampling a representative sample may be compromised, or generally if sample is not representative of what the team reported in service delivery. Method 2 may be more likely to produce incorrect estimates if the timespan of chart review dates considerably predates the time of when the team completed the Excel spreadsheet.

Which Method to Use?

Evaluators are encouraged to compute estimated service penetration rates using both methods 1 and 2. It is common that both result in the same rating. There are times where they could result in different ratings, as is the case for both EP2. SEE and EP3. WMR services above. In such cases, the next step is to round back to "Other data" to re-review the overall weight of the information and how it impacted decisions in how much to adjust the team's reported service penetration rate (and refer to Table 25 below). Another step is to consider the impact of a non-representative sample (Method 2 is often then more accurate).

Full Responsibility for Integrated Treatment for Co-Occurring Disorders (EP1) Excel spreadsheet Definition and Instructions: *These include services provided by the* COD specialist *as well as other team members well-versed in integrated, stage-wise treatment for COD. Core services include: (1) systematic and integrated screening and assessment and interventions tailored to those in (2) strategies to assist those in early stages of change readiness (e.g., outreach, MI) and (3) and strategies to assist those in later stages of change readiness (e.g., MI, CBT, relapse prevention). Integrated treatment for co-occurring disorder services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, client schedules). NOTE: To be considered a group participant, client attends group at least one time per month. To be counted as an individual integrated treatment for COD participant, the duration and frequency of therapy sessions should be at least 20 minutes per week. Be sure to also include clients whom the team is attempting to actively engage; these attempts should be documented in the client's chart.*

Worksheet 4. Method 1 **Calculating the number of clients receiving integrated treatment for COD (EP1) from the team (numerator).**	**Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving integrated treatment for co-occurring disorders (COD) from the team (**Excel spreadsheet, column B**)? Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served. • Engagement-related services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5. • If client noted as also receiving services from a **non-ACT provider (see column B**), selectively exclude from this count those clients who, after follow-up questioning to team leader or other staff, are accessing these non-ACT services in lieu of team's emphasis of integrated treatment for COD (however, exclude complimentary programs, such as detoxification, residential integrated treatment for COD, and self-help groups).	**Team Reports: (A)** 42%	
Team Hope example. The team reported that 42 of the 100 clients (42%) were receiving integrated treatment for COD from the team.		
B. What percent of all charts reviewed were observed to have any integrated treatment for COD at all (i.e., regardless of it being systematically provided and regardless of quality was judged high or low)? **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 25%	
The results of **Team Hope's** Chart Review found that 5 of 20 (25%) charts were judged to provide some integrated treatment for COD, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of integrated treatment for COD? (this information may inform how much of an adjustment to make to team's report) • Calculate the percent of charts observed with "high quality" examples of integrated treatment for COD (i.e., # of those judged high quality / # judged to have some integrated treatment for COD). • Calculate the percent of charts observed with "systematic delivery" of integrated treatment for COD (i.e., # of those judged systematic / # judged to have some integrated treatment for COD).	**Other Data: (C)** 20% "high quality;" 40% "systematic;" and other examples judged to be weak	

• Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned integrated treatment for COD interventions in person-centered plans and/or client schedules, and reliance on other non-ACT COD services.		
The results of **Team Hope's** Chart Review found that 1 of 5 charts (20%) were judged to be of "high quality," and that 2 of 5 (40%) were systematically delivered. There was limited notation of planned integrated treatment for COD interventions in client schedules, and examples tend to be vague and somewhat mixed in regard to reflecting appropriate stage-wise treatment.		
Calculating percent of clients receiving service (numerator): Compare Steps **A with B**. If there is a significant discrepancy (e.g., a **difference of 15 percentage points or more**) between these two estimates, adjust from their original reported penetration in the direction of data observed in Step B (chart data). The extent of this adjustment depends on other data sources (see Step C). We recommend using either thirds or quarters to adjust team's reported percent (e.g., a discrepancy of 30 points could be divided in thirds (10, 20, 30), and how many "thirds" used to adjust would depend on other data sources (see Step C)); clear "moderate" findings may suggest cutting the difference in half. Also, refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. Other Tips: • If team reports that all/nearly all clients are receiving the service, then consider adjusting closer to chart review data as the sample would be representative of reported practice (i.e., by default, it reflects Method 2 described below). • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • Regardless if using Method 1 or 2 to calculate percent receiving integrated treatment for COD services, if examples cited are clearly a departure from best practices (e.g., all noted examples were judged to be of "low quality" due to there being a high use of confrontational, active treatment only services), consider rating a "1" for this item.	Estimated percent of those receiving integrated treatment for COD from the team (**Numerator)**: 31%	
As an example, there was a discrepancy of 17 percentage points between what **Team Hope** reported (42%) and what was observed in the charts (25%), with other data sources overall suggesting a lower level of practice. Given what was observed in Step C, evaluators chose to cut the difference in thirds, dividing 17 by 3 (17/3 = 5.7) and reducing the team's report by two-thirds the difference (i.e., 11.4 percentage points (42-11.4 = 30.6%, or 31%).		

Worksheet 5. Method 2. **Calculating the percent of clients receiving integrated treatment for COD (EP1) from the team (numerator).**	**Number or Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving integrated treatment for COD from the team (**Excel spreadsheet, column B**)? Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served. • Engagement-related integrated treatment for COD services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • If client noted as also receiving services from a **non-ACT provider (see column B**), selectively exclude from this count those clients who, after follow-up questioning to team leader or other staff, are accessing these non-ACT services in lieu of team's emphasis of integrated treatment for COD (however, exclude complimentary programs, such as detoxification, residential integrated treatment for COD, and self-help groups). • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.	**Team Reports: (A)** 42%	
Team Hope example. The team reported that 42 of the 100 clients (42%) were receiving integrated treatment for COD services from the team.		
B. What percent of those indicated as receiving integrated treatment for COD from the team (Excel spreadsheet, column B) were found to receiving such services, per the chart review? Refer to the **Chart Review Tally Sheet Part I** (Refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 63%	
Team Hope example: In the sample of 20 charts reviewed, 8 charts (40%) were of clients to whom the team had reported to be providing integrated treatment for COD services. The results of Team Hope's chart review found that 5 of 8 (63%) charts were judged to provide some integrated treatment for COD services, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of integrated treatment for COD? (This information may inform how much of an adjustment to make to team's report.) • Calculate the percent of charts observed with "high quality" examples of integrated treatment for COD (i.e., # of those judged high quality / # judged to have some integrated treatment for COD). • Calculate the percent of charts observed with "systematic delivery" of integrated treatment for COD (i.e., # of those judged systematic / # judged to have some integrated treatment for COD). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned integrated treatment for COD interventions in person-centered plans and/or client schedules, and reliance on other non-ACT COD services.	**Other Data: (C)** 20% "high quality;" 40% "systematic;" and other examples judged to be weak	
Team Hope's chart review found that 1 of 5 charts (20%) were judged to be of "high quality," and that 2 of 5 (40%) were systematically delivered. There was limited notation of planned integrated treatment for COD interventions in client schedules, and examples tend to be vague and somewhat mixed in regard to reflecting appropriate stage-wise treatment.		

Calculating percent of clients receiving service (numerator): If the percent found in Step B was at least 90%, then we recommend using the percent the team reported in Step A as the numerator. If the percent found in Step B is lower than 90%, consider adjusting the team's report using these guidelines: If other data sources are moderate to high (Step C), then you will apply the percent found in Step B following these rules: • Take the percent found in Step B and add 10 to it (e.g., 63% + 10 = 73%) *Why add 10? As we are generalizing the findings from the sample to the total caseload, adding 10 helps reduce potential error if the sample underrepresented the work of the team. When other data sources are generally favorable (Step C), we are more inclined to add in this margin of potential error.* • Apply this percent to what the team reported in Step A. For example, 73% is applied to the team's original report of 42%, which is 0.73 X 0.42 = 0.31 (X 100) = 31% If other data sources are low to moderate (Step C), then you will apply the percent found in Step B following these rules: • Take the percent found in Step B and apply this percent to what the team reported in Step A. For example, 63% is applied to the team's original report of 42%, which is 0.63 X 0.42 = 0.26 (X 100) = 26%. • If other data sources (Step C) indicate a lower quality overall, the evaluators have discretion to reduce the percentage in Step B down by 10. As an example, if Step C was judged to be overall low (very few to no examples judged high quality, nearly none systematic, and weak to generic examples provided), then the 63% may be reduced to 53%. The final adjustment then would be 0.53 X 0.42 = 0.22, or 22%. Refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • If there is reason to believe the team underreported their services, consider relying more on Method 1 process. Regardless if using Method 1 or 2 to calculate percent receiving integrated treatment for COD, if examples cited are clearly a departure from best practices (e.g., all noted examples were judged to be of "low quality" due to there being clear departures from best practices, such as high use of urine drug analyses or screens and use of confrontation, consider rating a "1" for this item.	Estimated percent of those receiving integrated treatment for COD from the team (**Numerator)**: 26%	
For **Team Hope,** 63% of the subsample were found to have documented integrated COD services. Other data sources (Step C) were not favorable, indicating a lower level of systematic delivery with majority having lower quality examples of work. Evaluators applied the 63% to the team's report of 42% (A), resulting an adjusted rate of 26% (0.63 X 0.42), thereby rating a "2." Likewise, they considered reducing further by 10 to 53% due to Step C results, and found that 0.53 X 0.42 = 0.22, or 22%, still rating a "2."		

Co-Occurring Disorders Specialist Interview:	
Let's take a look at the Excel spreadsheet (column B) and the number of clients who directly receive integrated treatment for COD from the team. Tell me more about what kinds of services you and the team provided to the clients listed in this spreadsheet. [Randomly select clients who were noted as receiving individual and/or group treatment, and ask more specifics about the services they receive. Inquire about a client noted as being in an earlier stage of change (column A) who is also receiving services.]	

Full Responsibility for EE services (EP2) Excel spreadsheet definition and instructions:
These include all services provided by the employment specialist as well as other team members well-versed in SEE services. Core services include: (1) engagement; (2) EE assessment; (3) job development; (4) job placement (including going back to school, classes); & (5) job coaching & follow-along supports (including supports in academic/school settings). Supported education services also should be noted in this column. EE services reported here should be reflected across other data sources (e.g., progress notes, treatments plans).

Worksheet 6. Method 1. **Calculating the number of clients receiving SEE services (EP2) from the team (numerator).**	**Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving SEE services from the team (**Excel spreadsheet, column E**)? Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served. • Engagement-related SEE services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Selectively exclude clients indicated as receiving EE services from a **non-ACT provider (see column E), and/or** are attending clubhouse and/or day treatment programming (column L) when follow-up questioning indicates it is in lieu of team's emphasis of EE services. • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.	**Team Reports: (A)** 25%	
Team Hope example. The team reported that 25 of the 100 clients (25%) were receiving SEE services from the team.		
B. What percent of all charts reviewed were observed to have any SEE services (i.e., regardless of it being systematically provided and regardless of quality was judged high or low)? **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 50%,	
The results of **Team Hope's** Chart Review found that 10 of 20 (50%) charts were judged to provide some SEE services, per review of progress notes alone.		

C. What did other data sources indicate as to the quality and systematic delivering of SEE services? (this information may inform how much of an adjustment to make to team's report) • Calculate the percent of charts observed with "high quality" examples of SEE services (i.e., # of those judged high quality / # judged to have some SEE service). • Calculate the percent of charts observed with "systematic delivery" of SEE services (i.e., # of those judged systematic / # judged to have some SEE services). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned SEE services in person-centered plans and/or client schedules, and reliance on other non-ACT SEE services.	**Other Data: (C)** 80% "high quality;" 90% "systematic;" and other examples judged to be strong	
The results of **Team Hope's** Chart Review found that 8 of 10 charts (80%) were judged to be of "high quality," and that 9 of 10 (90%) were systematically delivered. SEE services were included in client schedules, and examples provided were good, clearly reflected a whole team effort, and were generally detailed and reflecting best practices. Also, the team reported assisting the majority of current employed clients in getting those jobs (see column I).		
Calculating percent of clients receiving service (numerator): Compare Steps **A with B**. If there is a significant discrepancy (e.g., a **difference of 15 percentage points or more**) between these two estimates, adjust from their original reported penetration in the direction of data observed in Step B (chart data). The extent of this adjustment depends on other data sources (see Step C). We recommend using either thirds or quarters to adjust team's reported percent (e.g., a discrepancy of 30 points could be divided in thirds (10, 20, 30), and how many "thirds" used to adjust would depend on other data sources (see Step C)); clear "moderate" findings may suggest cutting the difference in half. Also, refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • If team reports that all/nearly all clients are receiving the service, then consider adjusting closer to chart review data as the sample would be representative of reported practice (i.e., by default, it reflects Method 2 described below). • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • Regardless if using Method 1 or 2 to calculate percent receiving SEE services, if examples cited are clearly a departure from best practices (e.g., all noted examples were judged to be of "low quality" due to there being a a clear departure from best practice, such as extensive preparation and reliance on development of "soft skills" before assisting with getting a job, consider rating a "1" for this item.	Estimated percent of those receiving SEE services from the Team (**Numerator)**: 30%	
As an example, there was a discrepancy of 15 percentage points between what **Team Hope** reported (25%) and what was observed in the charts (50%), with other data sources overall suggesting a high level of practice. Evaluators chose to increase the team's reported percent by one-third of the difference (i.e., 15/3 = 5), resulting in 30% (25 + 5).		

Worksheet 7. Method 2. **Calculating the percent of clients receiving SEE (EP2) from the team (numerator).**	**Number or Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving SEE services from the team (**Excel spreadsheet, column E**)? Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served. • Engagement-related SEE services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Selectively exclude clients indicated as receiving EE services from a **non-ACT provider (see column E), and/or** are attending clubhouse and/or day treatment programming (column L) when follow-up questioning indicates it is in lieu of team's emphasis of EE services. • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.	**Team Reports: (A)** 25%	
Team Hope example. The team reported that 25 of the 100 clients (25%) were receiving SEE services from the team.		
B. Percent of clients in Step A who were noted as receiving SEE service at all (i.e., regardless of it being systematically provided and regardless of quality was judged high or low), per the **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 100%	
In the sample of 20 charts reviewed, 8 charts (40%) were of clients to whom the team had reported to be providing SEE services. The results of **Team Hope's** chart review found that 8 of 8 (100%) charts were judged to provide some psychiatric rehabilitation, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of SEE services? (this information may inform how much of an adjustment to make to team's report) • Calculate the percent of charts observed with "high quality" examples of SEE services (i.e., # of those judged high quality / # judged to have some SEE service). • Calculate the percent of charts observed with "systematic delivery" of SEE services (i.e., # of those judged systematic / # judged to have some SEE services). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned SEE services in person-centered plans and/or client schedules, and reliance on other non-ACT SEE services.	**Other Data: (C)** 100% "high quality;" 100% "systematic;" and other examples judged to be strong	
Team Hope's Chart Review found that 8 of 8 charts (100%) were judged to be of "high quality," and that 8 of 8 (100%) were systematically delivered. SEE services were included in client schedules, and examples provided were good, clearly reflected a whole team effort, and were generally detailed and reflecting best practices. Also, the team reported assisting the majority of current employed clients in getting those jobs (see column I).		
Calculating percent of clients receiving service (numerator): If the percent found in Step B was at least 90%, then we recommend using the percent the team reported in Step A as the numerator. If the percent found in Step B is lower than 90%, consider adjusting the team's report using these guidelines: If other data sources are moderate to high (Step C), then you will apply the percent found in Step B following these rules:		

• Take the percent found in Step B and add 10 to it (i.e., if Step B found 40%, you would add 10 to get 50%). *Why add 10? As we are generalizing the findings from the sample to the total caseload, adding 10 helps reduce potential error if the sample underrepresented the work of the team. When other data sources are generally favorable (Step C), we are more inclined to add in this margin of potential error.* • Apply this percent to what the team reported in Step A (i.e., if the team had reported 30% in Step A, then you would "apply" 50% by: 0.50 X 0.30 = 0.15 (X 100) = 15% If other data sources are low to moderate (Step C), then you will apply the percent found in Step B following these rules: • Take the percent found in Step B and apply this percent to what the team reported in Step A. For example, 40% is applied to the team's original report of 30%, which is 0.40 X 0.30 = 0.12 (X 100) = 12%. • If other data sources (Step C) indicate a lower quality overall, the evaluators have discretion to reduce the percentage in Step B down by 10. As an example, if Step C was judged to be overall low (very few to no examples judged high quality, nearly none systematic, and weak to generic examples provided), then the 40% (from Step B) may be reduced to 30%. The final adjustment then would be 0.30 X 0.30 = 0.09, or 9%. Refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • If there is reason to believe the team underreported their services, consider relying more on Method 1 process. • Regardless if using Method 1 or 2 to calculate percent receiving SEE services, if examples cited are clearly a departure from best practices (e.g., all noted examples were judged to be of "low quality" due to there being a a clear departure from best practice, such as extensive preparation and reliance on development of "soft skills" before assisting with getting a job, consider rating a "1" for this item.	Estimated percent of those receiving SEE services from the team **(Numerator):** 25%	
For **Team Hope,** 100% of the subsample were found to have documented SEE rehabilitation. Other data sources (Step C) were favorable, indicating a high level of systematic delivery and high quality examples of work. Evaluators rated based on the team's original percent as all reported were found to have strong evidence of SEE services. Thus, 25% would be used as the numerator. [Note: Method 2 is less sensitive to detecting team's underreporting of their work, which was the case here for Team Hope.]		

Employment Specialist Interview:	
Let's take a look at the Excel spreadsheet *(column E)* ***and the number of clients who directly receive EE services from the team. Tell me more about what kinds of services you and the team provided to the clients listed in this spreadsheet.*** [Randomly select clients who are noted as receiving services, and inquire about what those services are; select clients noted as being competitively employed (column F), and corroborate how the team may have assisted in obtaining that position (column I).]	

Full Responsibility for WMR Services (EP3)
Excel spreadsheet definition and instructions:

These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. Examples of such services include development of WRAP and provision of the IMR curriculum. These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. WMR services reported here should be reflected across other data sources (e.g., progress notes, treatment plans). ***NOTE: When completing the column for the provision of WMR services, please specify the type of service that the client is receiving (e.g., IMR group, individual WRAP).***

Worksheet 8. Method 1. **Calculating the number of clients receiving manualized WMR services (EP3) from the team (numerator).**	**Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving manualized WMR services from the team (**Excel spreadsheet, column K**)? Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served.	**Team Reports: (A)** 12%	
• Engagement-related WMR services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients.		
• Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.		
Team Hope example. The team reported that 12 of the 100 clients (12%) were receiving WMR services from the team.		

B. Percent of clients noted as receiving manualized WMR service at all (i.e., regardless of it being systematically provided and regardless of quality was judged high or low), per the **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data). The results of **Team Hope's** Chart Review found that 2 of 20 (10%) charts were judged to provide some manualized WMR, per review of progress notes alone.	**Chart Review Results: (B)** 10%	
C. What did other data sources indicate as to the quality and systematic delivering of manualized WMR services? (this information may inform how much of an adjustment to make to team's report) • Calculate the percent of charts observed with "high quality" examples of WMR services (i.e., # of those judged high quality / # judged to have some WMR service). • Calculate the percent of charts observed with "systematic delivery" of WMR services (i.e., # of those judged systematic / # judged to have some WMR services). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned WMR services in person-centered plans and/or client schedules, whether the WMR manual is actually used in services (e.g., WRAPs are being completed), or mostly referred to as a resource (e.g., there is focus on discussing client's "toolbox" without completing WRAPs). The results of **Team Hope's** Chart Review found that 1 of 2 charts (50%) were judged to be of "high quality," and that 1 of 2 (50%) were systematically delivered. Although planning was lacking in specified interventions and there was limited notation of planned WMR interventions in client schedules. Examples tended to be limited, but having some detail.	**Other Data: (C)** 50% "high quality;" 50% "systematic;" and other examples judged to be strong.	
Calculating percent of clients receiving service (numerator): Compare Steps **A with B**. If there is a significant discrepancy (e.g., a **difference of 10 percentage points or more**) between these two estimates, adjust from their original reported penetration in the direction of data observed in Step B (chart data). The extent of this adjustment depends on other data sources (see Step C). We recommend using either thirds or quarters to adjust team's reported percent (e.g., a discrepancy of 15 points could be divided in thirds (5, 10, 15), and how many "thirds" used to adjust would depend on other data sources (see Step C)); clear "moderate" findings may suggest cutting the difference in half. Also, refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • If team reports that all/nearly all clients are receiving the service, then consider adjusting closer to chart review data as the sample would be representative of reported practice (i.e., by default, it reflects Method 2 described below). • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • Regardless if using Method 1 or 2 to calculate percent receiving WMR services, if examples cited are clearly a departure from best practices. As an example, there was a discrepancy of 2 percentage points between what **Team Hope** reported (12%) and what was observed in the charts (10%), with other data sources overall suggesting a moderate level of practice. Evaluators therefore used the team's report of 12%.	Estimated Percent of those receiving SEE services from the Team (**Numerator)**: 12%	

Worksheet 9. Method 2. **Calculating the percent of clients receiving manualized WMR services (CP8) from the team (numerator).**	**Number or Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving manualized WMR services from the team (**Excel spreadsheet, column K**)? Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served.	**Team Reports: (A)** 12%	
• Engagement-related manualized WMR services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients.		
• Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.		
Team Hope example. The team reported that 12 of the 100 clients (12%) were receiving manualized WMR services WMR services from the team.		
B. Percent of clients in Step A who were noted as receiving manualized WMR services at all (i.e., regardless of it being systematically provided and regardless of quality was judged high or low), per the **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 67%	
In the sample of 20 charts reviewed, 3 charts (15%) were of clients to whom the team had reported to be providing manualized WMR services (this is a highly representative sample). The results of **Team Hope's** Chart Review found that 2 of 3 (67%) charts were judged to provide some manualized WMR services, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of manualized WMR services? (this information may inform how much of an adjustment to make to team's report) • Calculate the percent of charts observed with "high quality" examples of WMR services (i.e., # of those judged high quality / # judged to have some WMR service). • Calculate the percent of charts observed with "systematic delivery" of WMR services (i.e., # of those judged systematic / # judged to have some WMR services). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned WMR interventions in person-centered plans and/or client schedules, whether the WMR manual is actually used in services (e.g., WRAPs are being completed), or mostly referred to as a resource (e.g., there is focus on discussing client's "toolbox" without completing WRAPs).	**Other Data: (C)** 50% "high quality;" 50% "systematic;" and other examples judged to be moderately strong	
Team Hope's Chart Review found that 1 of 2 charts (50%) were judged to be of "high quality," and that 1 of 2 (50%) were systematically delivered. Although planning was lacking in specified interventions and there was limited notation of planned manualized WMR services in client schedules, several good examples were provided by interviewed staff.		
Calculating percent of clients receiving service (numerator): If the percent found in Step B was at least 90%, then we recommend using the percent the team reported in Step A as the numerator. If the percent found in Step B is lower than 90%, consider adjusting the team's report using these guidelines: If other data sources are moderate to high (Step C), then you will apply the percent found in Step B following these rules:		

• Take the percent found in Step B and add 10 to it (i.e., if Step B found 67%, you would add 10 to get 77%). *Why add 10? As we are generalizing the findings from the sample to the total caseload, adding 10 helps reduce potential error if the sample underrepresented the work of the team. When other data sources are generally favorable (Step C), we are more inclined to add in this margin of potential error.* • Apply this percent to what the team reported in Step A (i.e., if the team had reported 12% in Step A, then you would "apply" 77% by: 0.12 X 0.77 = 0.09 (X 100) = 9% If other data sources are low to moderate (Step C), then you will apply the percent found in Step B following these rules: • Take the percent found in Step B and apply this percent to what the team reported in Step A. For example, 67% is applied to the team's original report of 12%, which is 0.67 X 0.12 = 0.08 (X 100) = 8%. • If other data sources (Step C) indicate a lower quality overall, the evaluators have discretion to reduce the percentage in Step B down by 10. E.g., if Step C was judged to be overall low (very few to no examples judged high quality, nearly none systematic, and weak to generic examples provided), then the 67% (from Step B) may be reduced to 57%. The final adjustment then would be 0.57 X 0.12 = 0.07, or 7%. Refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • If there is reason to believe the team underreported their services, consider relying more on Method 1 process. • Regardless if using Method 1 or 2 to calculate percent receiving WMR services, if examples cited are clearly a departure from best practices, consider rating a "1" for this item.	Estimated Percent of those receiving manualized WMR services from the Team **(Numerator)** 9%	
For **Team Hope,** 65% of the subsample were found to have documented manualized WMR services. Other data sources (Step C) were favorable. Evaluators increased the 65% up to 75% and was applied to the team's report of 12%, resulting in 9% (0.75*0.12).		

Peer Specialist Interview:	
Do you provide any manualized wellness management and recovery (WMR) services? *[If yes:]* ***Let's take a look at the Excel spreadsheet and the number of clients who have received manualized WMR services from the team.*** [Query for quality of services based on what is reported; whether the WMR service is formal and/or manualized.] ***Tell me more about what kinds of services you and the team provided to the clients listed in this spreadsheet*** (randomly select clients marked as receiving specific WMR services and ask for additional information to ascertain that the interventions were indeed manualized).	
Clinician Interview:	
Do you provide any manualized wellness management and recovery (WMR) services? [If yes:] ***Let's take a look at the Excel spreadsheet (column K) and the number of clients who directly receive manualized WMR services from the team.*** [Query for quality of services based on what is reported. Prompt for specific strategies used in IMR or WRAP, as well as gauge whether other deliberate, but less formal, WMR strategies are used.] ***Tell me more about what kinds of services you and the team provided to the clients listed in this spreadsheet*** *(randomly select clients marked as receiving WMR services and ask what is being provided).* ***Do you provide any Wellness Management and Recovery Services like IMR or WRAP?***	

Calculating the Denominator:

% of clients needing and/or wanting service

(see base rates listed below)

To determine the denominator, we refer to standardized base rates that are thought to reflect the percentage of ACT clients who would want these services, as well as those who may not expressed that they want, but appear to need these services and would benefit from further engagement in that particular service domain.

Extrapolating from published research and expert opinion, a conservative base rate is used for estimating the percent of clients who need/want integrated treatment for COD and EE services. It is assumed that *at least* 40% of ACT clients will need/want these services. It is assumed that all ACT clients will need/want WMR services, but a slightly more conservative estimate of 90% is used to calculate need/want to allow for client choice and measurement error.

We estimated that ***at least* 20%** of ACT clients will need/want the following service:

- Manualized WMR Services

We estimated that ***at least 40%*** of ACT clients will need/want the following services:

- Integrated Treatment for COD [1]
- EE Services

[1]If the team's reported rate of COD (see Excel spreadsheet, column A) exceeds 40%, then use their count as the denominator (e.g., it is common for more urban ACT teams to serve a higher rate of individuals with COD). If the team's reported rate is less than 40%, then use the suggested base rate of 40%; it is assumed that poor screening and assessment practices can result in a lower rate. The team may present an argument defending their original estimate, such as cultural and/or regional factors and/or program policies that have resulted in lower rates (e.g., having a separate COD ACT team). Query the team leader, as appropriate.

Service	Numerator (Method 1)	Numerator (Method 2)	Denominator	Final Calculation (Method 1)	Final Calculation (Method 2)
EP1. Integrated Treatment COD	31%	26%	42%	31/42 = 74%	26/42 = 62%
EP2. SEE Services	30%	25%	40%	30/75 = 75%	25/40 = 63%
EP3. Manualized WMR Services	12%	9%	20%	12/20 = 60%	9/20 = 45%

Table 25. A Description of Observed Data Given Actual Service Penetration: A Reference Guide for Evaluators.

Service penetration level	Considering the Evidence
High (75 – 100%) Rating 4 or 5	For a team that provides a high level of service penetration, evidence will be observed across most or all data sources. Of the approximate number of clients expected to want/need that particular service (e.g., 40% of total caseload for EE services), at least 75% of reviewed sampled charts (see Chart Review Tally Sheet Part I) will have service of interest documented in the progress notes. Service will be commented on during the observation of daily team meeting (i.e., reported contacts involving specialty services, and scheduled contacts to address client's specialty service needs), and a relatively large breadth of specialty services being provided. Likewise, there will be few clients who are participating in other non-ACT psychosocial programs (e.g., clubhouse, day treatment programming), which may reflect a lack of EE and/or wellness service activities. The specification of specialty service interventions will likely be very precise for a team that has fully embraced this practice.

Moderate (50%) Rating 2 or 3	For a team that provides a moderate level of service penetration, evidence will be observed across several data sources. Of the approximate number of clients expected to want/need that particular service (e.g., 40% of total caseload for EE services), between 40 and 60% of reviewed sampled charts (see Chart Review Tally Sheet Part I) will have service of interest documented in the progress notes. Service will be commented on during the observation of daily team meeting (i.e., reported contacts involving specialty services, and scheduled contacts to address client's specialty service needs), the breadth of specialty services being provided may be limited and reflect less systematic implementation of the specialty service.
Low (30% or less) Rating 1 or 2	For a team that provides a low level of service penetration, evidence will be observed across very few data sources—e.g., chart review (no or very few charts have notes that make mention of specialty services, and/or statements about the intervention may be vague; one or fewer treatment plans make note of specialty service), observation of daily team meeting (i.e., no mention of specialty services), and specialty services, when observed, lack breadth. Specialty service activities do not appear to be systematically delivered or follow from a plan (per the definition provided in Excel spreadsheet).

*Note that these heuristic guidelines are intended to provide examples of observed evidence at three distinct levels of service penetration (high, moderate, and low). For teams providing more intermediate levels (moderate-high or low-moderate), evaluators should take into consideration the overall weight of the evidence, considering the three levels provided here. Data on service penetration summarized in Chart Tally II should be used to support, or adjust (upwards or downwards), the team's reported penetration rate, considering the number of clients assumed to want/need that service; refer to appropriate Worksheet that is included in these rating guidelines.

	1	2	3	4	5
EP1 Full Responsibility for Integrated Treatment for Co-Occurring Disorders (COD)	Less than 20% of clients in need of integrated treatment for COD are receiving them from the team.	20 - 49% of clients in need of integrated treatment for COD are receiving them from the team.	50 - 74% of clients in need of integrated treatment for COD are receiving them from the team.	75 - 89% of clients in need of integrated treatment for COD are receiving them from the team.	90% or more of clients in need of integrated treatment for COD are receiving them from the team.
EP2 Full Responsibility for Employment and Educational (EE) Services	Less than 20% of clients in need of employment and educational services are receiving them from the team.	20 - 49% of clients in need of EE services are receiving them from the team.	50 - 74% of clients in need of EE services are receiving them from the team.	75 - 89% of clients in need of EE services are receiving them from the team.	90% or more of clients in need of EE services are receiving them from the team.
EP3 Full Responsibility for Wellness Management and Recovery (WMR) Services	Less than 20% of clients in need of WMR services are receiving them from the team.	20 - 49% of clients in need of WMR services are receiving them from the team.	50 - 74% of clients in need of WMR services are receiving them from the team.	75 - 89% of clients in need of WMR services are receiving them from the team.	90% or more of clients in need of WMR services are receiving them from the team.

EP4. Integrated Treatment for Co-Occurring Disorders (COD)

Definition: The TEAM practices from a model aligning with integrated treatment for co-occurring disorders (COD) where the TEAM (1) considers interactions between mental illness and COD; (2) does not have absolute expectations of abstinence and supports harm reduction; (3) understands and applies stages of change readiness in treatment; (4) is skilled in motivational interviewing; and (5) follows cognitive-behavioral principles.

Rationale: The integrated treatment for co-occurring disorders, delivered within the larger integrated treatment for co-occurring disorders that reflects many practices across the TMACT, attends to the concerns of both SMI and co-occurring disorders for maximum opportunity for recovery and symptom management. It is important that the integrated treatment for co-occurring disorders is embraced by all team members.

DATA SOURCES (*Denotes primary data source)

Team Leader Interview

What do you think is the goal for clients with co-occurring disorders with respect to substance use?	
How does your team view abstinence versus reduction of use? [Attend to whether goals are individualized and vary from more immediate abstinence to harm reduction given clients' stages of change readiness.]	
[Select from Excel three clients noted to be in an early stage of change, cross-reference the ID key to have name available, and for each:] ***What is the team's understanding of how*** (insert client) ***use is impacting their mental health? How is their mental health impacting their use? What other reasons might*** (client's name) ***be using?***	
Does your team employ harm reduction tactics?" **[If "yes"]** ***What are some examples?*** [Prompt to get at least five examples.]	
In what ways is confrontation used?	

Are you familiar with a stage-wise approach to substance use treatment? [If yes:] ***Can you give some examples of how your program uses this approach?*** (Attend to discussion of engagement and MI strategies and also active substance use counseling. Is the team directly providing services or referring out?) ***In what ways does your team use urine drug screens or other types of monitoring?*** ***If someone is interested in reducing or <u>stopping their substan</u>ce use, what types of interventions would you use to assist them?*** [Listen for examples of <u>cognitive</u> behavioral techniques.] ***Who would you refer to AA, NA or any other self-help groups? What about detox programs?*** [Seek examples.]	
Psychiatric Care Provider Interview	
Can you tell me a little bit about how you work with clients with comorbid substance use problems?	

What do you consider when prescribing medications and have you used medications to address substance use? [Probe for whether provider is a) willing to prescribe psychiatric medications despite active substance use; b) whether there is greater attention to prescribing addictive substances, such as benzodiazepines; and c) whether the provider has used medications to directly treat substance use (e.g., clozapine to reduce alcohol and drug use in schizophrenia, naltrexone to reduce cravings and intoxicating effects, or acamprosate to reduce intensity and duration of relapses). Responses are pertinent for criteria #1 - #2 in particular. Note, to receive full credit, the psychiatric care provider should voice some awareness that these are treatment options, and have strategically used them to address comorbid substance use.]	
Co-Occurring Disorders Specialist Interview*	
Could you summarize your fellow team members' views of treating clients with comorbid substance use problems? [Probe for whether there is agreement or disagreement among staff in how to work with clients who are actively using. *Do some staff promote more traditional substance use treatment approaches, which may include referring out to other providers to address substance use?*]	
Peer Specialist	
How would you describe your team's approach to supporting people with co-occurring substance use and mental health disorders?	

Clinician Interview*	
Now we are going to talk about your team's work with people with co-occurring substance use.	
[Select from Excel three clients noted to be in an early stage of change, cross-reference the ID key to have name available, and for each:] ***What is the team's understanding of how*** (insert client) ***use is impacting their mental health? How is their mental health impacting their use? What other reasons might*** (client's name) ***be using?***	
What do you think is the goal for clients with COD with respect to their substance use? How does your team view abstinence versus reduction of use? [attend to whether goals are individualized and vary from more immediate abstinence to harm reduction given clients' stages of change readiness.]	
Does your team employ harm reduction tactics? [If yes:] *What are some examples?*	
In what ways is confrontation used?	
Are you familiar with a stage-wise approach to substance use treatment? [If yes:] *Give some examples of how your program uses this approach.* [Attend to discussion of engagement and MI strategies and also active substance use counseling. Is the team directly providing services or referring out?]	

In what ways does your team use urine drug screens or other types of monitoring? ***If someone is interested in reducing or stopping their substance use, what types of interventions would you use to assist them?*** [Listen for examples of cognitive behavioral techniques.] ***Who would you refer to AA, NA or any other self-help groups? What about detox programs?***	

ITEM RESPONSE CODING

Rating Guidelines

This item is intended to be an approximate measure of the team's adherence to an evidence-based approach to integrated treatment for COD, both philosophically (i.e., do they embrace these principles within their core belief set) and in practice (i.e., do they apply these principles in their work with clients). Judgment of whether a specific criterion is fully vs. partially met should consider multiple data sources. This item is focused on the practice of the entire team. As it is unlikely that you will be able to interview each team member, use team leader interview as primary data source, but also consider information gathered from COD specialist, other staff, content of progress notes, and discussions observed during daily team meeting.

Refer to Table 26 below to determine if criteria are met at all, partially, or fully. If the program is fully based in integrated treatment for COD principles, the item is coded as a "5."

Table 26. Integrated Treatment for Co-Occurring Disorders (COD)

Criteria for the WHOLE TEAM:	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: considers interactions between mental illness and COD	Most team members' understanding of the interplay between mental illness and substance appears more superficial or believe one is to be addressed before the other.	Evidence is mixed: some team members clearly appreciate the interaction of mental illness and substance use, while others' understanding appears more superficial or believe one is to be addressed before the other.	All or nearly all team members appear to consider the interaction between mental illness and COD, and recognize the importance of simultaneously addressing both. The team works to understand how substance use, mental health symptoms, and environment may be influencing one another, both positively and negatively. No team member believes in parallel or sequential treatment of mental illness and substance use disorders.

Criterion #2: does not have absolute expectations of abstinence and supports harm reduction	All or nearly all team members have absolute expectations of abstinence and do not value the harm reduction model, OR one or two members strongly hold to these values of abstinence over harm reduction and their beliefs have negatively affected the team and work with clients.	Most all team members appear to practice from a harm reduction model, and do not have absolute expectations of abstinence. One or two members appear to have conflicting views, but these deviations appear to have minimal impact on the team and work with clients.	All or nearly all team members appear to practice from a harm reduction model. No one has absolute expectations of abstinence.
Criterion #3: understands and applies stages of change readiness in treatment	Most team members do not understand stages of change readiness theory and therapeutic implications, OR embrace competing theories (e.g., sees substance use as a character flaw, or believes that all clients who use require AA/NA).	There is considerable variation across team members in their understanding and accurate application of stages of change readiness theory, OR most appear to understand the theory, but are less systematic in their application in practice.	All or nearly all team members appear to understand and accurately apply stages of change readiness theory when delivering treatment to those with COD.
Criterion #4: is skilled in MI	Most team members are not skilled in motivational interviewing techniques.	There is considerable variation across team members in their accurate understanding of MI, OR team members' understanding is somewhat superficial and practice is more limited.	All or nearly all team members appear to understand and accurately practice MI techniques when working with clients with COD. Examples of MI techniques include: use of open-ended questions; use of affirmations; use of reflective listening; use of summaries; examining pros and cons of use (decisional balance); scaling desires and abilities.
Criterion #5: follows CBT principles	Most team members do not follow CBT principles, possibly due to a lack of understanding of their own OR conflicting treatment philosophies.	There is considerable variation across team members in their accurate understanding of CBT principles, OR team members' understanding is somewhat superficial and practice is more limited.	All or nearly all team members appear to understand and apply CBT principles when working with clients who have comorbid substance use problems. Examples of CBT interventions include: understanding the relationship between thoughts, feelings, behaviors, and consequences; recognizing and replacing irrational thoughts; replacing maladaptive behaviors with competing adaptive behaviors.

	1	2	3	4	5
EP4. Integrated Treatment for Co-Occurring Disorders (COD)	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met.	Team primarily operates from integrated treatment for COD, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team is fully based in integrated treatment for COD principles, FULLY meeting all 5 criteria.

EP5. Supported Employment & Education (SEE)

Definition: The TEAM practices from a model aligning with evidence-based supported employment and education (SEE) and the TEAM:
(1) Values competitive work as a goal for all clients;
(2) Believes and supports that a client's expressed desire to work is the only eligibility criterion for SEE services;
(3) Believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment;
(4) Believes and supports that placement should be individualized and tailored to a client's preferences; and
(5) Believes that ongoing supports and job coaching should be provided when needed and desired by client, and has provided such supports.

Rationale: SEE is an evidence-based practice for adults with SMI. Successful implementation of SEE will involve full participation of all team members.

DATA SOURCES (* denotes primary data source)

Excel spreadsheet (columns F, G, H & I)

Examine the types of places individuals are working (competitive vs volunteer), whether the settings appear to be varied, and the extent to which the team has helped people obtain employment.

Employment Specialist Interview*

Could you summarize your fellow team members' views of assisting clients in obtaining competitive employment? [Probe for whether there is agreement or disagreement among staff in how to assist clients around their work goals. Do some staff believe in extensive pre-vocational assessment or believe that some clients are not ready for employment, possibly because of substance use or poor personal care?]	

Team Leader Interview	
What is the team's overall approach to employment and educational services within the team? [Prompt for familiarity with SEE including the criteria listed above. Reference Excel spreadsheet for more information on the team's efforts in helping people with competitive employment.]	
Peer Specialist	
How would you describe your team's approach to supporting people who are interested in employment?	
Clinician Interview*	
Now let's talk about employment and education services provided by the team. ***How does the employment specialist come to work with certain clients? How does the team make that decision?*** [Seek information regarding team's active role in engaging interest and referral.] ***What work programs do ACT clients access (e.g., sheltered work programs, work crews, transitional employment)?***	

Are there examples of where the team is providing training to help a person prepare to get a job? [If yes, ask for examples and probe for whether the team is actively doing job search at the same time, how much this preparation may be stalling a job search, and generally if any "work readiness" criteria are being considered.] ***Are you familiar with supported employment & education?*** [If yes:] *What is your understanding of the model?* ***Can you provide examples of how team members encourage and support competitive employment?*** [Select clients who are noted in the Excel spreadsheet to be in competitive employment, cross-reference the ID key to have name available, and ask:] ***Can you describe how the team is providing supports to*** *(insert client name)* ***to help*** *(him or her)* ***keep this job? Do you know if this client has a Career Profile and have you ever seen it?*** [If yes, further inquire how they use information in the Career Profile.]	

If a client says they want to work full-time, but you know they will lose their benefits, what do you typically do?	

ITEM RESPONSE CODING

Rating Guidelines

This item is intended to be an approximate measure of the team's adherence to evidence-based SEE, both philosophically (i.e., do they embrace these principles within their core belief set) and in practice (i.e., do they apply these principles in their work with clients). Judgment of whether a specific criterion is Fully vs. Partially met should consider multiple data sources. This item is focused on the practice of the entire team. As it is unlikely that you will be able to interview each team member, use the team leader interview as primary data source, but also consider information gathered from employment specialist, other clinicians, and discussions observed during daily team meeting.

Refer to Table 27 below to determine if criteria are met at all, partially, or fully. If the program is fully based in SEE principles, the item is coded as a "5."

Table 27. Supported Employment & Education (SEE)

Criteria for the WHOLE TEAM	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: values competitive work as a goal for all clients	Most team members do not appear to embrace the value of competitive employment as an immediate, achievable goal, as reflected by their work with clients.	Evidence appears to be mixed: the value of competitive employment varies considerably across team members, and/or the value is articulated, but with less consistent application in practice.	All or nearly all team members appear to value the importance of competitive work, particularly as an immediate, achievable goal, and these values are reflected in their work with clients.
Criterion #2: believes and supports that a client's expressed desire to work is the only eligibility criterion for SEE services	Most team members appear to value "work readiness" criteria other than client's expressed desire to work. These other "work readiness" criteria may include sobriety, medication adherence, and symptom stability (e.g., no active hallucinations, motivation and follow-through).	Evidence appears to be mixed: some team members appear to hold other less consequential "work readiness" criteria as more important than client's expressed desire to work.	All or nearly all team members appear to believe that the client's expressed desire to work is the only eligibility criterion for SEE services, as reflected in both their expressed values and work with clients. No team member appeared to hold less consequential "work readiness" criteria as more important than client's expressed desire to work. "Work readiness" refers to expecting clients to address/reduce/resolve symptoms and behaviors (poor self-grooming, substance use, medication adherence) before assisting with SEE.

Table 27. Supported Employment & Education (SEE)			
Criteria for the WHOLE TEAM	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #3: believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment	Most team members strongly value extensive prevocational assessment practices (e.g., spending a lot of time completing assessment paperwork, evaluating skills via work groups, expecting clients to complete work trials).	Evidence appears to be mixed: some team members appear to value the practice of extensive prevocational assessment, which may include any trial experience testing soft skills (e.g., punctuality, attention, social skills, grooming) thereby delaying progress toward achieving employment.	All or nearly all team members appear to value the importance of on-the-job assessment and limits extensive prevocational assessment, which can unnecessarily delay progress toward the employment goal. No team member appeared to clearly advocate for extensive work trials and pre-vocational assessments.
Criterion #4: believes and supports that placement should be individualized and tailored to a client's preferences (See Excel spreadsheet columns F, G, H & I)	Most team members appear to minimize the importance of individualized and tailored placements. The team may heavily rely on a few select competitive and noncompetitive employment opportunities known to hire their clients.	Evidence appears to be mixed: some team members appear to minimize the importance of individualized and tailored placements, possibly preferring a few select competitive and noncompetitive employment opportunities known to hire their clients.	All or nearly all team members appear to believe that placement should be individualized and tailored to a client's preferences, as evidenced by their expressed values and observed practices (e.g., efforts to identify and share a range of employment opportunities in community). It appears that client's preferences are being attended to, as indicated by a broad array of competitive job settings, per the Excel spreadsheet (e.g., not all are fast food).
Criterion #5: believes that ongoing supports and job coaching should be provided when needed and desired by client	Most team members appear to <u>not</u> view themselves as being responsible for providing ongoing supports and coaching to clients as they engage in educational or work activities.	Evidence appears to be mixed: some team members appear not to value the team's role as providing ongoing supports (e.g., some team members may share stories about when they didn't think job coaching and support was helpful or that it isn't the role of the team or employment specialist to provide).	All or nearly all team members appear to believe that ongoing supports and job coaching should be provided when needed and desired by the client, as evidenced by expressed values and observed practices (e.g., team members consistently report that they think these strategies help and that it is the role of the ACT team to provide, team members may describe when they or others on the team have directly provided such coaching and support).

EP5. Supported Employment & Education (SEE)	**1**	**2**	**3**	**4**	**5**
	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met.	Team primarily embraces SEE, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team fully embraces SEE and FULLY meets all 5 criteria.

EP6. Engagement & Psychoeducation with Natural Supports

Definition: The FULL TEAM works in partnership with clients' natural supports. As part of their active engagement of natural supports, the team:
(1) Provides education about their loved one's illness;
(2) Teaches problem-solving strategies for difficulties caused by illness; and
(3) Provides &/or connects natural supports with social & support groups.
Rationale: It is the ACT team's role to work collaboratively with clients to help identify natural supports in the community who may be able to provide a role in supporting the client's recovery and furthering community integration. Once these individuals are identified and clients consent to any contact with them, the ACT team should actively engage them by providing them with the information necessary to help them to further support the ACT client and either directly provide or connect them with supports in the community.

DATA SOURCES (* denotes primary data source)

Excel spreadsheet (column X)

Examine responses to contacts with clients' natural supports. While referring to the ID key to access names, randomly select examples to further query about the nature of those contacts.

Daily Team Meeting - Observation Form (p. 189-192)

Listen for whether team members have had contacts with natural supports and the extent to which their contact reflects education, problem-solving and overall support.

Team Leader Interview*

Now I'm going to ask you some questions about how the team works with families and natural supports. ***How does the team typically work with clients' families and natural supports?***	
Can you provide (additional) examples of the team educating natural supports about their loved one's illness? [Prompt for clarification if examples represent proactive or reactive encounters with supports]	
Can you provide (additional) examples of the team working with natural supports and the client to develop better problem-solving skills? [Prompt for clarification if examples represent proactive or reactive encounters with supports]	

In what (other) ways has the team helped connect natural supports to support groups? Randomly select specific clients listed in the Excel spreadsheet with whom the team has had contact with natural supports, reference the ID key to access names, and ask: ***Describe what the team did with this particular client's natural supports.***	
Clinician Interview	
Now I'm going to ask you some questions about how the team works with families and natural supports. ***How does the team typically work with clients' families and natural supports?*** [Note: if the same client examples come up across interviews, prompt for other examples to understand scope of practice.] ***Can you provide (****additional****) examples of the team educating natural supports about their loved one's illness?*** [Prompt for clarification if examples represent proactive or reactive encounters with supports]	

Can you provide (**additional**) examples of the team working with natural supports and the client to develop better problem-solving skills? [Prompt for clarification if examples represent proactive or reactive encounters with supports] ***In what (**other**) ways has the team helped connect natural supports to support groups?*** Randomly select specific clients listed in the Excel spreadsheet with whom the team has had contact with natural supports, reference ID key to access names, and ask: ***Describe what the team did with this particular client.***	
Client Interview	
Does the team ever talk to anyone important in your life—such as family, close friends, landlords, church members, or employers? [If yes, probe what the content of those contacts are—do they appear to be quality contacts with the intent of better serving the client?]	

ITEM RESPONSE CODING
Rating Guidelines
Please refer to Table 28 below to determine if services are provided at all, partially, or fully.

Table 28. Engagement & Psychoeducation with Natural Supports			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
As part of their active engagement of natural supports, team: Service #1: provides education about their loved one's illness;	Team very rarely educates clients' natural supports about their loved one's illness, possibly due to a lack of priority or a lack of understanding of their own.	Examples are provided, but they appear to be isolated and/or reactive/passive to a situation. Team does not appear to prioritize their role as an educator for clients' natural support system.	Team seeks opportunities to educate clients' natural supports about their loved one's illness. This is done both informally (through phone calls, prearranged meetings, chance encounters) and through more structured psychoeducation meetings (individual and/or group). Examples suggest this work is occurring across more than a select group of clients.
Service #2: teaches problem-solving strategies for difficulties caused by illness;	Team very rarely, if at all, works with clients' natural supports to develop effective problem-solving skills.	Examples are provided, but they appear to be isolated and/or reactive/passive to a situation (e.g., a crisis event). Team does not appear to prioritize their role as a point of intervention within the clients' natural support system.	Team embraces their role as an interventionist by proactively addressing problems that exist in the natural support system, including teaching clients' supports problem-solving strategies (e.g., to reduce conflict and increase a sense of a shared mission. Examples suggest this work is occurring across more than a select group of clients.
Service #3: provides &/or connects natural supports with social & support groups.	Team does not appear to attend to the social support needs of clients' natural supports.	Team provides several examples, but this practice is not systemically and routinely provided by the team.	Team directly provides support groups, coordinates with NAMI or other community-based agencies that provide such groups, and/or routinely provides this information to natural supports. The latter could include information in the ACT admission packet and/or group information provided to natural supports when they first meet with them.

	1	**2**	**3**	**4**	**5**
EP6. Engagement & Psychoeducation with Natural Supports	Team does not provide any of the specified services with clients' natural supports.	1 or 2 services are provided.	ALL 3 services are provided, but 2-3 services only PARTIALLY.	ALL 3 services are provided but 1 only PARTIALLY.	ALL 3 services are FULLY provided by team.

EP7. Empirically-Supported Psychotherapy

Definition: The team: (1) deliberately provides individual and/or group psychotherapy, as specified in the treatment plan; (2) uses empirically-supported techniques to address specific symptoms and behaviors; and (3) maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services. Although all team members can be trained to effectively use therapeutic techniques, such as cognitive behavioral therapy and motivational interviewing, the team also ideally has a licensed therapist.

Rationale: In addition to providing case management/support, psychiatric rehabilitation (e.g., skills training), and wellness and recovery services to clients, core clinical members of the ACT team should be competent in and provide empirically-supported psychotherapy to address the wide range of clinical and behavioral issues for this population (e.g., psychotic symptoms, anxiety, depression, criminal justice involvement, symptoms consistent with borderline personality disorder).

DATA SOURCES (* denotes primary data source)

Excel spreadsheet (column M)*

Examine how many clients are receiving psychotherapy services from the team. Note the specific types of psychotherapeutic techniques reported.

Chart Review

Review the extent to which the team delivers empirically-supported therapies, and how routine are these contacts (e.g., weekly, every other week).

Team Leader Interview

Do clients on your team ever receive psychotherapy from the team? [If yes]: *Tell me more about the kind of psychotherapy services provided. Is it formally or more informally provided? Is there anyone on your team who is a trained therapist? Have other staff received training in specific psychotherapies and/or receive supervision in the use of psychotherapy (e.g., CBT or MI)? Does psychotherapy tend to take place in the context of other services provided (e.g., providing supportive counseling while grocery shopping)?* [Refer to clients noted as seeing <u>non-ACT team therapists in column M</u> of the Excel spreadsheet; select clients and inquire as to why they are seeing a non-ACT therapist.]	

Clinician Interview*	
Note that team members chosen for this clinician interview should ideally include one qualified therapist. ***Do you provide psychotherapy?*** *How would you describe your style in therapy? What kind of therapy do you typically offer? What does it look like? Can you give me examples of specific methods you use with clients who have specific symptoms or concerns?* Give specific examples (e.g., someone with social anxiety; someone with significant trauma history). ***What kind of resources or training materials does your team use to guide delivery of therapy to clients on the team?*** (Prompt for specific worksheets, homework, diary cards/logs. See Table 29 below for examples of manuals.). Refer to responses in column M of the Excel spreadsheet and prompt for: ***About how often is psychotherapy provided—weekly, every other week, monthly, as needed? How long is each session, on average?*** ***Let's talk about this client—tell me about your therapeutic approach in working with them. What about this client?***	

Daily Team Meeting
Listen for how these two clinicians and other team members report on specific psychotherapeutic interventions during their report in the daily team meeting.

ITEM RESPONSE CODING

Rating Guidelines

Note: These services include group or individual therapeutic approaches that are based on established theory and techniques. Therapies are selected and employed to address a specific set of symptoms or behaviors (e.g., relaxation and exposure therapy for anxiety disorders; CBT for schizophrenia or depression; dialectical behavioral therapy for emotional dysregulation). Psychotherapy sessions are deliberate, tied to clients' goals and written into the client's treatment plan. Ideally, psychotherapy is conducted by a trained therapist, but other staff may be equipped to deliver select therapies given appropriate training and supervision. Psychotherapy services reported here should be reflected across other data sources (e.g., progress notes, treatments plans). MI should not be counted for this item and EP1. Full Responsibility for Integrated Treatment for Co-Occurring Disorders unless the client is receiving MI for both COD and for other areas of their life where they may be in an earlier stage of change readiness (e.g., in contemplation about moving from unsafe housing). Both sets of interventions must be documented separately in the treatment plan.

Rating is guided by a combination of the clinician report on the extent to which there is a team member providing empirically-supported therapy and the number of clients who receive such formal therapy by the team as identified in the Excel spreadsheet. Use the daily team meeting and chart review (document whether psychotherapy interventions were specified in the charts in the Chart Review Notes) to corroborate other data sources. Use Table 29 below to guide rating for this item.

Formula for Criterion #3	$\frac{\text{\# of clients who receive deliberate, empirically-supported psychotherapy in the past year}}{\text{Total \# of clients served on the ACT team}}$ **x 100**

Table 29. Empirically-Supported Psychotherapy

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: Team deliberately provides individual and/or group psychotherapy, as specified in the treatment plan	Team does not provide any psychotherapy or all psychotherapy is provided "on the fly" with little to no tie to clients' treatment plans.	Data sources provide some evidence that at least one licensed team member is deliberately providing psychotherapy on a regular basis, but this is only evident in a few of those data sources (e.g., examples were reported in staff interviews, but little to no evidence of such observed in the chart review). These sessions are still regularly scheduled with the client to address a problem or advance toward a goal outlined in the treatment plan, where the therapeutic intervention is clearly noted in the plan. Alternatively, the team may not have a licensed therapist, but some team members appear adept at using therapeutic techniques (e.g., CBT) in their work.	Data sources provide strong evidence that at least one team member is deliberately providing psychotherapy on a regular basis, and this person is licensed to provide therapy. Data attesting to this practice is observed in staff interviews, chart reviews, and client/team schedules. Sessions must be regularly scheduled with the client to address a problem or advance toward a goal outlined in the treatment plan, where the therapeutic strategy or strategies are clearly noted in the plan. Alternatively, although there is no licensed therapist on the team, the team is strongly adept at core therapeutic techniques (CBT and MI) and application of these techniques was evident across multiple data sources.

Table 29. Empirically-Supported Psychotherapy			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #2: Team uses empirically-supported techniques to address specific symptoms and behaviors	Team either: • does not provide empirically-supported therapy, or • provides examples of only providing therapy that is atheoretical and ill-defined ("supportive counseling") and/or not empirically-supported for this population (e.g., psychodynamic approaches) and/or • demonstrates inappropriate application of techniques (e.g., using person-centered (i.e., Rogerian) therapy to address a phobia or psychosis, which could more effectively be treated with CBT).	Data sources provide some evidence that team clinicians are adept at delivering empirically-supported psychotherapy for specific symptoms and/or behaviors, but there is a mix of use of atheoretical and/or ill-defined ("supportive counseling") approaches.	Data sources provide enough evidence that team clinicians are adept at delivering empirically-supported psychotherapy for specific symptoms and/or behaviors. Such evidence includes specific and appropriate examples of interventions and the type of symptoms and behaviors addressed, as well as application of resources and/or training in these particular interventions (please see Table 30 for guidance).
Criterion #3: Team maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services (See Excel spreadsheet column M)	In the past year, less than 25% of clients have received a deliberate, empirically-supported psychotherapeutic intervention.	In the past year, 25-39% of clients have received a deliberate, empirically-supported psychotherapeutic intervention. *Do not credit the team for individuals reported to be receiving empirically-supported psychotherapy when the team is not providing it (no credit on #1 and #2)	In the past year, at least 40% of clients have received a deliberate, empirically-supported psychotherapeutic intervention. *Do not credit the team for individuals reported to be receiving empirically-supported psychotherapy when the team is not providing it (no credit on #1 and #2)

Table 30. Examples of Empirically-Supported Psychotherapies		
Diagnosis/Symptoms	**Name of Therapy**	**Example Manuals/Handbooks**
Schizophrenia Spectrum Disorders	Cognitive Behavioral Therapy	*Cognitive Behavioral Therapy of Schizophrenia (Kingdon & Turkington, 1994)* *Cognitive-Behavior Therapy for Severe Mental Illness: An Illustrated Guide (Wright, Turkington, Kingdom, & Basco, 2009)* *Cognitive-Behavioral Social Skills Training for Schizophrenia: A Practical Treatment Guide (Granholm, McQuaid, & Holden, 2016)*
	Cognitive Remediation Therapy	*Cognitive Remediation for Psychological Disorders: Therapist Guide (Medalia, Revheim, & Herlands, 2009)* *Cognitive Remediation Therapy for Schizophrenia: Theory & Practice (Wykes & Reeder, 2005)*

Table 30. Examples of Empirically-Supported Psychotherapies		
Diagnosis/Symptoms	**Name of Therapy**	**Example Manuals/Handbooks**
Panic Disorder with or without Agoraphobia; Specific phobias; Social Anxiety Disorder; Generalized Anxiety Disorder	Cognitive Behavioral Therapy	*Mastery of Your Anxiety and Panic (Barlow, Craske, & Meadows, 2005)* *Mastering Your Fears and Phobias (Craske, Antony, & Barlow, 2006)* *The Anxiety and Phobia Workbook, 4th Edition (Bourne, 2005)*
Depressive Disorder	Acceptance and Commitment Therapy (ACT)	*Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change (Hayes, Strosahl, & Wilson, 1999)*
	Cognitive Behavioral Therapy	*Cognitive Therapy: Basics and Beyond (Beck, 1995)* *Cognitive Therapy of Depression (Beck, Rush, Shaw, & Emery, 1979)*
	Interpersonal Therapy	*Comprehensive guide to interpersonal psychotherapy (Weissman, Markowitz, & Klerman, 2000)*
	Problem-Solving Therapy	*Problem-Solving Therapy: A Treatment Manual (Nezu, Nezu, & D'Zurilla, 2012)*
Bipolar Disorder	Cognitive Behavioral Therapy	*Cognitive Behavioral Therapy for Bipolar Disorder (Basco & Rush, 1996)*
	Interpersonal and Social Rhythm Therapy	*Treating Bipolar Disorder: A Clinician's Guide to Interpersonal and Social Rhythm Therapy (Frank, 2007)* *Integrated Family and Individual Therapy for Bipolar Disorder (Miklowitz, Richards, George et al., 2003)*
Borderline Personality Disorder; Chronic suicidality and self-harm	Dialectical Behavior Therapy	*Cognitive-Behavioral Treatment of Borderline Personality Disorder (Linehan, 1993, 2015)* *Skills Training Manual for Treating Borderline Personality Disorder (Linehan, 1993, 2015)*
Post-Traumatic Stress	Exposure Therapy	*Prolonged Exposure Therapy for PTSD (Foa, Hembree, & Rothman, 2007)*
	Trauma Recovery and Empowerment Model (TREM)	*Trauma Recovery & Empowerment: A Clinician's Guide to Working with Women in Groups (Harris, 1998)*
Early stages of change readiness (not specific to treating a co-occurring disorder when rating this item)	Motivational Interviewing	*Motivational Interviewing: Preparing People for Change (Miller & Rollnick, 2002)* *Motivational Interviewing in the Treatment of Psychological Problems (Arkowitz, Miller, Rollnick, & Westra, 2008)*

	1	2	3	4	5
EP7. Empirically-Supported Psychotherapy	Team does not provide psychotherapy to clients. No criteria are met.	1 to 2 criteria are PARTIALLY met.	Criterion #1 is PARTIALLY met and criteria #2 and #3 is at least PARTIALLY met OR Team FULLY meets both criteria #1 and #2, but does not meet criterion #3.	Team FULLY meets criterion #1, PARTIALLY meets criterion #2, and at least PARTIALLY meets criterion #3. OR Team FULLY meets both criteria #1 and #2 and only PARTIALLY meets criterion #3.	Team FULLY meets all 3 criteria.

EP8. Supportive Housing

Definition: The team embraces supportive housing, including: (1) assisting clients in locating housing of their choice (e.g., providing multiple housing options, including integrated housing); (2) respect for clients' privacy within residence; (3) assistance in accessing affordable, safe/decent, and permanent housing; and (4) assured ongoing tenancy rights, regardless of clients' progress or success in ACT services.

Rationale: It is the ACT team's role to work collaboratively with clients to identify and secure safe, affordable, decent housing in the community that provides them with the rights of tenancy under landlord tenant laws. The team provides flexible support and services to help meet clients' needs and preferences in these housing settings. Studies have shown that supportive housing has helped clients progress in recovery and maintain residence in the community.

DATA SOURCES (* denotes primary data source)

Housing Specialist, if available OR Team Leader Interview*

In what kinds of settings are clients living? Do they typically have a choice of where to live or have many options? [As needed, prompt for types of settings and household composition (families; congregate, supervised, independent settings; group, individual) and range of options the team can offer. Review entries on Excel spreadsheet (column O) indicating who lives in settings where more than 25% of units/rooms are designated for tenants with a disability or special need. Use these entries to query Team Leader to further distinguish between who appears to be in more congregate vs. integrated settings. Further query about whether clients who live in congregate setting with others with disabilities actually chose to live in that setting, and what is the team doing to help them move into more independent settings. Exclude those in hospitals or jailed, although this information may be of relevance for other items. Make note of residential settings occupied by a majority of individuals with disability/special needs, although these units/rooms are not specifically designated for these groups; may include in qualitative feedback if reflects a prominent agency behavior that may undermine client choice in housing].	

Review those indicated as being homeless in column O. [Randomly select specific clients listed in the Excel spreadsheet who are living in supervised residential settings, see ID reference to access names, and ask:] ***Describe what the team is doing with this client around their current residential placement (e.g., did the team help them move in and why, is there current action to help this person move out, and what does that look like?).*** ***What is the team doing to help homeless clients access affordable and safe housing?*** ***Does the team have access to clients' residences, such as having a key? If so, for approximately how many clients? Under what conditions does the team access clients' residences?*** [Review entries on Excel spreadsheet (columns P and Q) regarding who is receiving a subsidy, is waitlisted to receive a subsidy, or is paying no more than 30% of income to live in a safe and affordable setting without a subsidy. Make sure that data are accurately entered so that individuals who may be living in affordable, but unsafe, environment are excluded.]	

What types of housing subsidies do these individuals receive? What has been the process for assisting clients in accessing housing subsidies? [Determine whether the team appears to be proactive in assisting clients with accessing subsidies so that they may move into more affordable, and likely safer, independent living residences. Are clients on subsidy waitlists?] ***Do any clients live in housing you consider to not be safe or decent (e.g., relatively clean, not in disrepair, does not pose a threat to the client in some way)? If so, which of the clients listed on the spreadsheet?*** ***Do any clients live in housing that is temporary and/or transitional (i.e., there is a limited timeframe for how long they can live there)? If so, which of the clients listed on the spreadsheet?*** ***Do some clients live in residences where the conditions in the lease go beyond what is typical of a common lease, such as including conditions for treatment participation and/or sobriety?*** [For those with requirements of treatment participation, is it specifically with ACT or any service program? Approximately how many have such contingencies written into the lease? Who was the last client evicted as a result of violating these specific terms of a lease? Query for the team's role in that eviction.]	

Client Interview	
Tell me a little bit about where you live. What do you like and not like about it? [Query for affordability, safety/decency, permanency, whether they live in an integrated or clustered setting, and if there are any requirements of them to remain in treatment or stay sober while living in residence.]	
How did you come to live in your current residence? [Probes: Did you have a choice about where to live? Did the ACT team talk with you about your housing options? Did you have more than one possibility suggested for housing?]	
Do you feel like you have the privacy that you want? [If necessary and appropriate, query for whether staff have access to their home.]	
How long do you get to stay where you currently live? Have you been told you have to move after a certain amount of time?	

Excel spreadsheet*
See Table 31 for specific questions and columns referenced for each criterion.

Chart Review and Daily Team Meeting
Examine charts for information about the nature of clients' residential settings, references to client preferences or other expressions of interests in housing alternatives, and staff access to housing. At the daily team meeting, listen for references to deliberations about housing and residential "placements" and how team members report on or plan for interactions around clients' residential interests.

ITEM RESPONSE CODING
Rating Guidelines
Refer to Table 31 below to determine whether, and to what extent, the team meets these five supportive housing criteria. The assessment of this item is based on the team's approach to assisting clients with housing, regardless of how this approach may be influenced by access to resources and/or policies and procedures external to the ACT team.

Table 31. Estimation of Credit for Four Supportive Housing Practices

Criteria, Definition, and Primary Data Source (marked *):	**No Credit**	**Partial Credit**	**Full Credit**
Criterion #1: Client choice: Clients typically live in housing of their choice (e.g., ideally living in residences typical of the community, without clustering people with disabilities and/or other special needs such as homelessness). **DATA SOURCES:** Excel spreadsheet (column O) and interview questions* While the team may report in the interview that some clients chose to live in congregate or clustered housing, do not adjust percentage, but note it in the qualitative item-level feedback.	Most clients (at least 70%) live in settings where at least 25% of the units/rooms are designated for tenants who meet disability related and/or special needs (e.g., homelessness) eligibility criteria. OR At least 25% of clients live in settings where at least 75% of the units/rooms are designated for tenant who meets disability related and/or homeless eligibility criteria.	Some clients (26% - 69%) live in settings where at least 25% of the units/rooms are designated for tenant who meet disability related and/or special needs (e.g., homelessness) eligibility criteria.	Few clients (25% or less) live in settings where at least 25% of the units/rooms are designated for tenants who meet disability related and/or special needs (e.g. homelessness) eligibility criteria.
Criterion #2: Privacy: Clients have control over whether and when staff enter their residence.	ACT staff has free access to client residences OR At least 40% of ACT clients are residing in supervised residential environments where privacy may be compromised by way of the living environment itself where there is less choice and freedom.	No partial credit.	ACT staff may not enter the client residence unless client invites them OR if the team has reason to believe the client is in crisis and/or has advanced directives for mental health conditions or other high needs (e.g., serious physical conditions) that require them to have extra support to live independently.

Table 31. Estimation of Credit for Four Supportive Housing Practices			
Criteria, Definition, and Primary Data Source (marked *):	**No Credit**	**Partial Credit**	**Full Credit**
Criterion #3: Affordable, safe/decent, and permanent housing: Clients pay a reasonable amount from their income (30% or less) toward their rent or mortgage plus basic utilities, partly as a result of the team's efforts to help them secure housing subsidies and other supports. Exclude individuals who are judged to not be in a safe/decent (e.g., not relatively clean, in disrepair) environment or are in temporary/transitional housing, per the team leader/housing specialist and client interviews. **DATA SOURCES:** Excel spreadsheet (columns P & Q) and client/staff interviews*	Few clients (less than 25%) pay a reasonable amount from their income to live in safe housing.	Some clients (26% - 74%) pay a reasonable amount from their income to live in safe housing.	Most clients (at least 75%) pay a reasonable amount from their income to live in safe housing.
Criterion #4: Tenancy rights: Clients' tenancy is *not* contingent on their progress or success in ACT services. **DATA SOURCES:** Excel spreadsheet (column R) and interview Questions* If "no credit" condition is true for more than one individual, then rate "no credit." To rate full credit, there are no instances where client's lease includes conditions related to successful engagement in ACT services (one or two exceptions may be allowed to still receive full credit). It is not uncommon for access to housing subsidies to require such conditions, resulting in no more than partial credit.	Tenancy is revoked based upon noncompliance with ACT services or failure to participate in other rehabilitative/clinical services (e.g., unwillingness to be seen by staff, and/or lack of progress, such as with substance use reduction or medication adherence). Exclude individuals who elected to live in sober living residences to advance their recovery, where such residences often require treatment participation (and sobriety) to remain in residence.	Clients are required to participate in ACT or other rehabilitative/clinical program, but tenancy is not contingent on progress (e.g., obtaining and maintaining sobriety, or adhering to medications).	Tenancy is not contingent in any way upon clients' participation in ACT or other rehabilitative/clinical service program (i.e., tenancy may be contingent on very basic contact with outreach program for the purpose of very minimal monitoring and engagement opportunities).

	1	2	3	4	5
EP8. Supportive Housing	Team meets no more than 1 criterion.	3 criteria PARTIALLY met OR 2 criteria met, at least PARTIALLY.	4 criteria met, with at least 2 PARTIALLY met OR 3 criteria met, with at least 1 criterion FULLY met.	ALL 4 criteria met, with up to 1 criterion PARTIALLY met (remaining 3 criteria are FULLY met).	ALL 4 criteria FULLY met.

PP1. Strengths Inform Treatment Plan

Definition: (1) The team is oriented toward clients' strengths and resources, and (2) clients' strengths and resources inform treatment plan development.

Rationale: Assessment of strengths alone does not necessarily result in strengths-based approaches to services. To ensure that they are applied within practice, it is important for strengths and resources to be transferred from the assessment and carried out within the treatment plan.

DATA SOURCES (* Denotes primary data source)

Chart Review* - Chart Review Log Part II (p. 197-198) and Chart Review Tally Sheet Part II (p.201-202)

Review treatment plans for three or more meaningful and personal strengths and resources identified in the assessment. Also review plans to determine whether strengths inform the plan itself (i.e., identified strengths are thoughtfully used or leveraged in efforts to move toward personal recovery goals or objectives).

Team Leader Interview*

Does your team routinely assess client strengths and resources? Where would we find these documented? [Acknowledge areas you may have already identified strengths in documentation.]	
How does your team use or apply the strengths and resources that are identified in their work with clients, including how plans are developed?	
[Go to Excel spreadsheet and randomly pick 2-3 clients]: ***Tell us a little bit about this client's strengths/resources and how the team is working with that client, given those particular strengths/ resources.***	

Clinician Interview*	
Do you routinely assess client strengths and resources? ***How do you use or apply the strengths and resources that are identified in your work with clients? Can you give us some examples?*** [If yes:] ***Where would we find that information in the charts?***	

ITEM RESPONSE CODING

Rating Guidelines

Use both the interview data and chart review as the primary data sources in rating this item. Use the Chart Review Log Part II at the end of this protocol to identify strengths and resources within the treatment plan. If strengths and resources are not reflected within the treatment plan goals and action steps, do NOT count that chart toward the percentage of charts that incorporate strengths/resources. Please see Table 32 for further guidelines in how to assess whether each criterion was met.

Table 32. Strengths Inform Treatment Plan

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team is oriented toward clients' strengths and resources[9]	The team does not appear to attend to clients' strengths and resources, instead focused on clients' limitations and problems AND/OR	The team variably attends to clients' strengths and resources (evidence was mixed across data sources; limited documentation of strengths/resources	The team is clearly attentive to clients' strengths and resources, with a process in place for more systematic assessment of strengths and resources (i.e., these attributes were consistently documented in assessments/plans) and orientation to those strengths in day-to-day work with clients is evident. Strengths and resources should include those attributes, skills and qualities that are individual and personal to the client, not simply team-generated strengths regarding the client's progress in treatment, such as medication or treatment adherence.

[9] Use Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate percentage of charts in which personal strengths and resources are assessed.

Table 32. Strengths Inform Treatment Plan			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	nearly all strengths or resources identified were team-generated based on the client's response to treatment (e.g., medication compliance, works well with the team).	was observed) OR some strengths or resources identified were team-generated based on the client's response to treatment (e.g., medication compliance, works well with the team).	Personal strengths may also include ways in which the client has handled difficult situations or persevered despite difficulties in the past. Note: Consider the quality and quality of strengths captured in documentation as well as the perspective and approach of the team, as observed in other data sources (e.g., daily team meetings, team member interviews).
Criterion #2: Clients' strengths and resources inform treatment plan develop-ment[9]	Very few, if any (less than 29%) of the reviewed treatment plans, clients' strengths and resources were not only assessed, but clearly informed the development of goals, objectives, and/or interventions.	For some (i.e., 30 – 64%) of the reviewed treatment plans, clients' strengths and resources were not only assessed, but clearly informed the development of goals, objectives, and/or interventions.	In at least 65% of the reviewed treatment plans, clients' strengths and resources were not only assessed, but clearly informed the development of goals, objectives, and/or interventions. For example: A client's strength was his artistic abilities and interests. In a goal related to his developing healthy relationships, an objective was to join a local art club that met monthly and integrate that goal into provision of individual IMR. A client's strength was her caretaking of others. To help encourage her developing cooking skills, staff collaboratively developed skills training interventions that involved helping her learn how to cook a weekly dinner for herself and a neighbor friend.

	1	**2**	**3**	**4**	**5**
PP1. Strengths Inform Treatment Plan	Strengths are not assessed (no criteria #1).	Team variably attends to clients' strengths and resources and strengths/ resources do not inform planning (Partial #1 only).	Team is clearly attentive to clients' strengths and resources, but clients' strengths and resources do not typically inform plan development (Full #1 and No credit #2) OR Team is variably attentive to strengths and uses this information to inform plans, but less systematically (Partial #1 and Partial #2).	Team is clearly attentive to clients' strengths and resources, which informed plan development for some (Full #1 and Partial #2).	Team is highly attentive to clients' strengths and resources, and gathers such information for the purpose of treatment planning (Full #1 and Full #2).

PP2. Person-Centered Planning

Definition: The team creates treatment plans using a person-centered approach, including:
(1) Development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting) and with the team, preferable the individual treatment team (ITT);
(2) Conducting regularly scheduled treatment planning meetings;
(3) Attendance by *key* staff (i.e., members of the ITT), the client, and anyone else they prefer (e.g., family), tailoring number of participants to fit with the client's preferences;
(4) Provision of guidance and support to promote self-direction and leadership within the meeting, as needed; and
(5) Treatment plan is clearly driven by the client's goals and preferences.

Rationale: Person-centered planning involves rethinking the traditional treatment planning process so that it is maximally responsive to an individual's expressed needs, preferences, and rights to self-determination. By planning a central role in planning their own services and goals, clients are empowered to make positive choices in their own lives, both within and outside the mental health system. Research suggests a linkage between person-centered planning, increased medication adherence, and service engagement.

DATA SOURCES (* Denotes primary data source)

Treatment Planning Meeting* - Observation Form (p. 193) and Chart Review Log Part II (p. 197-198) and Chart Review Tally Sheet Part II Tally (p. 201-202)

Observe at least one treatment planning meeting and note elements of person-centered planning.

Chart Review*

Observe the quality and person-centeredness of Person-Centered Plans. Did they appear to result for a person-centered process?

Team Leader Interview

Can you walk us through how the team comes to determine which interventions they will be providing to each client? [Query further to determine how plans come to be created and who is involved in that process, how often it is occurring.]	

Clinician Interview	
NOTE**:** For all interview questions pertaining to the treatment planning process, try to reserve these questions for after observation of the treatment planning meeting, if possible, and reflect on observations when posing questions. ***How often do treatment planning meetings occur?***	
What is the process of getting the information you need to inform treatment planning meetings with clients?	
Who typically attends these meetings? What percentage of clients attends their treatment planning meetings? [Ask follow-up questions of how commonly the team uses the model described to you.]	
What is the client's role in their treatment planning meetings?	
How do you ensure that clients understand what the treatment planning meeting is and their role within their own treatment and this particular meeting?	

Peer Specialist Interview	
See previous response to this question in ST8.	
Client Interview	
Do you know what your treatment plan (or use the term used by the client or agency) ***is?*** ***Do you ever attend your treatment planning meetings or meetings with the team?*** ***What are those meetings like for you?*** ***Who typically attends those meetings?*** ***Do you feel like what you're saying is being heard by your team when coming up with your plan?***	

ITEM RESPONSE CODING

Rating Guidelines

Observation of the treatment planning meeting should drive the rating on this item with confirmation of observations with staff interviews (i.e., determine whether what was observed reflected typical practice). As described in the introduction, it is important to plan for attendance at this meeting ahead of time when you plan your site review. If attendance in the treatment planning meeting isn't possible, ask team members to describe their treatment planning process during your interviews with them and examine treatment plans in the charts to corroborate what you hear from team members.

Consider whether the team (esp. client's ITT) appears to use their routine contacts to assess clients' needs and wants, and begin formulating a treatment plan prior to the meeting. Are key team members included in the meeting, or is it just the primary case coordinator or, conversely, the entire team? Is there an effort to help the client take some control and responsibility for directing this meeting?

Refer to Table 33 below to determine if criteria are met at all, partially, or fully. If all five elements of ACT person-centered planning are present, rate as a "5."

Table 33. Person-Centered Planning			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting).	The team does not appear to attend to relevant treatment planning data during their routine contacts with clients prior to the treatment planning meeting. During the treatment planning meeting, there is little reference to what staff already know about the client, as relevant to the new treatment plan.	There appears to be some attention to collecting relevant treatment planning data during routine contacts leading up to the treatment plan meeting with the client, but this is done inconsistently, and/or this information is not used to develop a formative treatment plan to be revised during the meeting with client.	The team uses routine contacts to assess clients' needs and wants, and begin formulating a treatment plan prior to the meeting. Pre-treatment plan meetings (i.e., among ITT members) help team members share and synthesize relevant assessment data. There may be multiple pre-treatment plan meetings like this and they can be very informal with only two or three members of the client's treatment team. By the time of the scheduled treatment planning meeting with the client and natural supports, it is clear that the team has collected some or all of the following information, which may then be used to create a formative plan to be revised during the meeting: • Gain feedback on what has worked/not worked as laid out in the treatment plan in the past (if this isn't their initial treatment plan); • Trouble-shoot how to resolve any current concerns with treatment and incorporate them into the treatment plan; and • Get a sense of the client's treatment and recovery goals to develop a formative treatment plan.
Function #2: Conducting regularly scheduled treatment planning meetings.	Treatment planning meetings are typically held more than every six months or not at all.	Treatment planning meetings are held less consistently (sometimes not every six months).	Treatment planning meetings are regularly held, typically at least every six months.
Function #3: Attendance by *key* staff, the client, and anyone else they prefer, tailoring number of participants to fit with the client's preferences.	Treatment planning meetings routinely do not include members of the treatment team, client, or others the client prefers/requests to participate. It may be the case that the "primary" care coordinator assigned to work with the client completes the plan with the client alone.	Treatment planning meetings less consistently include key members of treatment team, clients, and/or others the client prefers/requests to be in the treatment planning meeting; OR The treatment planning meeting includes all participants named above, but it appears to be an overwhelming experience for clients and is not adapted to fit their experience and preferences. In such cases, sometimes clients may opt out of the treatment planning meeting (i.e., "They don't want to come in and meet with all of us.")	Treatment planning meetings consistently include: • Members of the client's ITT; • The client; and • Others the client prefers /requests to be at the meeting (e.g., family, other natural supports). However, if the client prefers to have fewer participants, the number of meeting participants is tailored to those preferences and may include a smaller group.

Table 33. Person-Centered Planning			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #4: Provision of guidance and support to promote self-direction and leadership within the meeting, as needed.	There is little to no evidence either within the meeting or outside of the meeting that the team provides coaching and support to clients to promote self-direction and leadership. The client is left to use their own existing skills.	There is some evidence of team guidance and support to promote client self-direction and leadership within the treatment planning meeting, but it appears to be absent at times (e.g., you observe a missed opportunity for guidance when a client is asked how the team can be more helpful in supporting their goal to go back to school and the client just says "I don't know;" the team moves on with what they would like to put in the treatment plan rather than querying more and providing some examples to choose from such as sitting down side-by-side and completing college applications).	While the treatment team may take an active role in facilitating the treatment planning meeting, the client's voice is heard and reflected and the team actively solicits his or her input throughout. It is clear that the team has either previously provided or currently provides guidance and support to the client within the meeting. Such guidance and support should focus on promoting self-direction and leadership within the meeting and in the client's treatment. Examples include: • Education about what the treatment plan is and how it fits with the client's recovery and life goals; • Education and guidance about the client's role in his or her own treatment with the ACT team and how to take an active lead in this process; • Education and guidance about the treatment planning meeting and how to self-advocate and have a more active voice in the process.
Function #5: Treatment plan is clearly driven by the client's goals and preferences and is structured in a manner to inform person-centered practices.	The treatment plan is not person-centered. Goals do not appear to reflect what client's wishes are, and remaining elements of the plan also do not appear to capture the client's preferences. stated in the team's words.	The evidence for the plan being driven by the client's goals and preferences is inconsistent throughout the plan (e.g., the goal appears recovery-centered, but remaining elements of the plan are not clearly person-centered).	The treatment team does not overly dictate the content of the treatment plan. The client's treatment and recovery goals and preferences (e.g., who they want to work with, what they want to work on) drive the content of the treatment plan, as indicated by the following: • Client's goals are stated in their own words, quoted or not; • Client's preferences for treatment are specified (e.g., which team members they'll work with, where they'd like to meet). • Interventions appear meaningfully tied to the client's stated goals.

	1	2	3	4	5
PP2. Person-Centered Planning	No more than 1 function of person-centered planning is performed OR 2 functions are performed, but not fully.	2 functions of person-centered planning are FULLY performed (3 are absent) OR 3 functions are performed at least PARTIALLY (3 are absent).	4 functions of person-centered planning are performed (1 absent) OR 5 functions performed, with 3 or more PARTIALLY performed.	ALL 5 functions of person-centered planning are performed, with up to 2 PARTIALLY performed.	ALL 5 functions of person-centered planning are FULLY performed.

PP3. Interventions Target a Broad Range of Life Domains

Definition: The team attends to a range of life domains (e.g., physical health, employment/education, housing satisfaction, legal problems) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in treatment plans and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs.

Rationale: Pursuit of a range of life goals is essential to recovery and a range of planned interventions are thereby needed to assist clients advance in their recovery. Daily team practices should reflect a breadth of interventions well beyond those typical of basic maintenance and case management (e.g., medication management, money disbursement, and grocery shopping).

DATA SOURCES (* Denotes primary data source)

Daily Team Meeting

Note the services and contacts planned for that day and the extent to which they reflect more than those that are typically clinically-defined (e.g., taking medications, staying out of the hospital, reducing symptoms). Scan Client Daily Log for breadth of services documented as being delivered.

Chart Review* - Chart Review Log Part II (p. 197-198) and Chart Review Tally Sheet Part II (p.201-202)

Review treatment plan goals (in charts) for presence of a diverse range of life areas and respective progress notes to determine if interventions focus on a broad range of life areas.

Weekly Client Schedules*

Review Weekly Client Schedules for planned service contacts and extent to which they focus on a broad range of life goals.

ITEM RESPONSE CODING

Rating Guidelines

Life domains address more than traditional clinical goals, such as medication management, symptom reduction, and staying out of the hospital. They include: Housing, Finances, Physical Health, Social/Relationships, Employment/Education, Independent Living Skills, Legal, Substance Use, and other areas of personal recovery, including targeted psychotherapy. The focus of PP3 is the planning and delivery of *interventions,* which are intended to result in a behavior/symptom change within these life domains; documentation of observations or commentary (e.g., remarking on client's poor self-care) are not considered implemented interventions, nor are case management tasks (distribution of money, per representative payeeship). Refer to Table 34 to determine if criteria are met at all, partially, or fully.

Table 34. Interventions Target A Broad Range of Life Domains			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: Team specifies interventions that target a range of life domains in treatment plans.	Less than 30% of plans reviewed have interventions targeting at least 3 life domains identified above OR less than 65% of plans have interventions targeting at least 2 life domains.	30- 64% of plans reviewed have interventions targeting at least 3 life domains identified above OR at least 65% of plans have interventions targeting at least 2 life domains.	At least 65% of treatment plans reviewed have interventions targeting at least 3 life domains. Life domains address more than traditional clinical goals, such as medication management, symptom reduction, and staying out of the hospital. Note that the focus is on interventions and not *goals.* Interventions addressing a range of life domains may be subsumed under one particular goal—e.g., an intervention to help client address housing maintenance (so environment is more hospitable to company) may follow a social skills training intervention, both subsumed under a Social/ Relationship goal.
Criterion #2: These planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs.	Less than 30% of charts reviewed document interventions targeting at least 3 life domains identified above OR less than 65% of plans have interventions targeting at least 2 life domains.	Approximately half of all clients (30-64%) receive interventions targeting at least 3 life domains identified above OR at least 65% of plans have interventions targeting at least 2 life domains.	Nearly all clients (65% of charts reviewed) receive interventions targeting at least 3 life domains. *Interventions* are intended to result in a behavior/symptom change within these life domains; documentation of observations or commentary (e.g., remarking on client's poor self-care) are not considered implemented interventions, nor are case management tasks (distribution of money per representative payeeship).
Alignment (Relevant for differentiating "4" and "5" ratings)	Less than 60% of the charts having some appreciable continuity between planned interventions (criterion #1) and implemented interventions (criterion #2).	No partial credit option.	Alignment is defined as at least 60% of the charts having some appreciable continuity between planned interventions (criterion #1) and implemented interventions (criterion #2). Refer to "C" of PP3 in the Chart Review Tally Sheet Part II (at the end of this protocol) and gauge extent to which there is alignment, which can impact ratings for anchors "4" and "5."

	1	**2**	**3**	**4**	**5**
PP3. Interventions Target a Broad Range of Life Domains	The team does not plan for and/or deliver interventions that reflect a breadth of life domains.	Team minimally plans for and/or delivers interventions that reflect life domains (PARTIAL credit for one criterion only) OR Team plans for but does not deliver a breadth of services (Full #1 only).	Team plans for and delivers interventions that reflect a breadth of life domains, but less systematically (PARTIAL #1 and PARTIAL #2) OR a larger breadth of services are planned for, but not in turn delivered (FULL #1 and PARTIAL #2).	Team delivers interventions that reflect a range of life domains to all clients (FULL #2), but interventions targeting a breadth of life domains are not systematically specified in treatment plans (PARTIAL #1 OR FULL #1, but lacking Alignment).	Team specifies interventions that target a range of life domains in treatment plans and these interventions are carried out in practice (FULL criteria #1 and #2 with Alignment).

PP4. Client Self-Determination and Independence

Definition: The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.

Rationale: ACT teams serve many individuals who, due to their psychiatric symptoms and cognitive impairments, need greater direction and oversight to help them remain safe in the community. This higher level of involvement in clients' lives may increase the team's potential for engaging in paternalistic and possible coercive interventions. It is important that teams appropriately balance interventions aimed to manage risks against interventions aimed to help clients direct and manage their own lives. Clients' needs for oversight and supervision from the team will vary and it is important that level of services is consistent with functioning and need. Areas of particular risk of excessive supervision include medications and money.

DATA SOURCES (***** Denotes primary data source)

Client Interview

Do you have any examples where a team member has worked with you to learn a new skill that helps you be more independent, such as a cooking skill, cleaning skill, or social skill?	
Do you ever feel like the ACT team tells you what to do—maybe being too directive with you? If yes, ask for examples [possible categories: what to wear, what to eat, whether and when to take medications, when to awake and go to bed, upkeep of residence, how to spend time during the day, where to work].	
Is the team your representative payee? If so, how often do they give you money? Do you feel like it is up to you how to spend your money? *Do they ever tell you how to spend your money?*	

Does the team watch you take your medications? *How often? Do you like how often they do this or do you think it is too often or not often enough?*	

Direct Observation of Services

Observe the language staff use with the client. Attend to the degree to which staff is directive with client. How respectful our staff with client, especially when in client's natural environment. Do staff take liberties when in client's personal environment (e.g., looking in refrigerator without permission). In general, to what degree do staff oversee the day-to-day activities of clients (e.g., what to wear, eat, do that day, etc.)? Does the level of supervision appear appropriate given client's level of functioning?

Daily Team Meeting

Observe the language used about clients in the daily team meeting. Note whether previous or planned contacts are directive in nature. Table 35 provides examples of language that reflects more direction and supervision vs. language that reflects greater promotion of independence and choice.

Team Leader Interview

Could you give me an example of how the team has helped a client weigh options to make a more informed choice or decision, even if some options were less desirable from the team's perspective? [Consider the meaningfulness of the choices described in these examples, as well as the team's role in helping client in the decision-making process. Examples of more meaningful choices would include deciding whether to attend a family functioning when there as a history of significant discord, or whether to discontinue taking a particular antipsychotic medication that has helped control many problematic symptoms, but has too many intolerable side effects. An example of a less meaningful choice includes deciding whether to have the team come out to see them in the morning or afternoon for medication supports.]	

Can you think of any examples where the team has intentionally withheld information from a client for the purposes of steering them toward a decision or behavior? [If yes] ***Can you tell me more about those instances?***	
[If 1 or more endorsed as having the agency or team as the representative payee:] ***I see from your report on the Excel spreadsheet*** *(column T)* ***that ___ clients have the agency or team assigned as their representative payee. Describe how clients come to have the team or agency as their representative payee.*** [An excessive number of clients with the team or agency as the payee may reflect a practice driven more by policy or orientation toward supervision of client behaviors rather than client needs. One study of ACT teams found that, on average, teams, or administrating agencies, served in the role of representative payee for 47% of the caseload, which can serve as a guide to judge excessive use of payeeship.] Also note what role the team plays in managing money allocation decisions when an agency external to the team serves as the representative payee for clients.	
Can you give an example of the last client that regained their own payeeship or someone the team has been working with to eventually become their own payee?	

Can you describe the last client the team helped move from a supervised setting to more independent setting? When was that and what types of supports were provided upon their move?	

Excel spreadsheet - (columns S, T, U, V, W)

How many clients are on involuntary commitment or conditional release?

Note the number of clients on payeeship and the extent to which the agency or team is the payee.

How many clients are on guardianship?

Note the number of clients for whom the team directly manages oral medications, as well as the number of an antipsychotic depot injection.

Although some clients make an informed decision to receive depot injections due to greater convenience and improved efficacy, some clients do not. Depot injections can be considered coercive and intrusive by some clients, and historically have been used with clients considered more resistant to taking oral medications. However, it is important to weigh rate information on the use of depot injections with what is learned in CT4 on the use of shared decision-making model.

ITEM RESPONSE CODING

Rating Guidelines

This item is largely impressionistic, although the impressions are informed by several data sources. Refer to Table 36 below to determine if criteria are met at all, partially, or fully. To be rated as a "5" on this item, the team, as a whole, appears to promote client independence and self-determination by helping clients develop greater awareness of meaningful choices available to them, honoring day-to-day choices, as appropriate, and teaching clients the skills required for independent functioning. ACT teams typically serve some clients who are in need of close oversight and more direction given functional/cognitive impairments secondary to their illness, but the team uses good clinical judgment to assure that the **level of direction and oversight is commensurate with the needs of the client and the team works hard to promote client's self-determination.**

Teams score lower on this item if they provide greater supervision and oversight that appear to be disproportionate to client needs. These teams tend to shy away from allowing clients to make their own mistakes or make daily choices that depart from what the team considers best. Also, with teams that do not embrace and prioritize the value of promoting client self-determination and independence, supervisory practices tend to be more universal, rather than individualized given unique needs and functioning impairments, resulting in a higher overall use of these practices. Conversely, teams may score lower on this item if they provide little in terms of proactive interventions intended to further develop clients' self-determination and independence; these teams may be providing very little guidance, both in practical skill-building and in imparting important information to expand clients' choices.

Table 35. Examples of Directive vs. Independence-Promoting Language	
Directive language	**Independence-promoting language**
"Joan was wearing her slippers again when I showed up yesterday. I told her she needed to put on real shoes or else I wouldn't be able to take her to the store."	"Joan was wearing her slippers again yesterday. I reminded her of the shoes she just bought and asked if she'd be willing to try them out as we headed to the store —just so we could see what she likes and doesn't like about them."
"Let's start swinging by Joe's house at 7:30 a.m. for his daily meds. That way, we can make sure he is getting up and not sleeping away his morning."	"Joe's always asleep when we arrive around 10 a.m. Let's ask him if he'd like us to show up earlier to help him start his day, at least two days a week. We should find out why he is staying in bed so late -- drowsiness, depression, no incentives to get out of bed? Maybe a simple coffee maker with a timer would do the trick."

Table 36. Client Self-Determination and Independence			
Practice	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Practice #1: helping clients develop greater awareness of meaningful choices available to them;	Team does not help clients develop a greater awareness of meaningful options and choices available to them; OR were observed (on several occasions) to purposely withhold information that would allow clients to make more meaningful choices, possibly for the purpose of directing behaviors.	There is *significant* variability across staff and/or clients in the extent to which the team helps clients develop a greater awareness of meaningful choices available to them (e.g., few relevant examples were provided, and/or examples of the team not taking the time to educate clients about options and choices were observed).	Team routinely assists clients in having a better awareness and understanding of their options to facilitate more informed decision-making. Example observations: Team leader easily generates solid examples of the team imparting information to help clients consider options and make choices in their lives: • One such decision was about a client's living circumstances and whether to remain living in a more affordable apartment with an abusive partner or move to less affordable housing without the abusive partner. • Another decision was about a client's plans to continue working with the team in light of an expiring involuntary commitment order. • Evaluators observed example of the team discussing a client whose ongoing substance use was creating financial problems; the team intended to sit down with the client and representative payee to draft three budget options that may or may not entail changes in current behaviors/living arrangements.
Practice #2: honoring day-to-day choices, as appropriate;	Team is largely unaware of the daily lives of most clients, thereby missing opportunity for respectful and therapeutic interventions; OR team tends to micromanage many of clients' day-to-day activities, likely because the team	There is *significant* variability across staff and/or clients in the degree to which day-to-day choices are honored. For example, team was generally observed to be respectful of clients' choices, but have taken an excessively hard stance	Team respects clients' decisions around day-to-day activities, including when to awake and go to sleep, what to eat, what to wear, how household is maintained, and with whom to associate. Maladaptive day-to-day behaviors may be addressed in a very respectful and therapeutic manner (e.g., teaching clients the importance of food safety and ridding refrigerator of spoiled food; selection of

Table 36. Client Self-Determination and Independence			
Practice	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	believes such a high level of direction benefits clients.	against clients who smoke cigarettes, often leveraging access to resources against abstinence from nicotine.	clothing that does not put self at risk of unwanted overtures or assault). NOTE: The team is assumed to meet this criterion unless data suggest otherwise—i.e., team appears to be more directive in day-to-day living decisions and behaviors, or largely unaware of such decisions/behaviors.
Practice #3: teaching clients the skills required for independent functioning. Team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.	Team provides little oversight, direction, and skill-building to promote more independence; OR team tends to "do for" clients and/or supervise behaviors (e.g., management of money, medication adherence, substance use, which includes excessive use of urine drug screens across clients) to avoid deleterious consequences.	There is *significant* variability across staff and/or clients in efforts to help clients develop independent living skills, thereby reducing dependence on the team. Some clients may have been observed as having more excessive oversight with minimal skill-building.	Team strives to help clients learn how to manage their lives by teaching them necessary life skills, thereby limiting the need for the team to supervise various areas of clients' lives.

	1	**2**	**3**	**4**	**5**
PP4. Client Self-Determination & Independence	None of the 3 practices are employed OR only 1 is employed (FULLY or PARTIALLY).	2 practices are employed (FULLY or PARTIALLY), with 1 absent.	3 practices are employed, with 2 to 3 PARTIALLY.	Team generally promotes clients' self-determination and independence. All 3 practices are employed, but 1 PARTIALLY employed.	Team is a strong advocate for clients' self-determination and independence. All 3 practices FULLY employed.

DAILY TEAM MEETING OBSERVATION FORM

ACT Team:	
Team leader:	**Date:**
Reviewer:	

Fidelity Scale Item	**Reviewer Notes**
OS3. Daily Team Meeting: Frequency & Attendance The team meets on a daily basis and all team members scheduled for that shift normally attend to review and plan service contacts with each client.	*Note team members present at observed daily team meeting:*
OS4. Daily Team Meeting (Quality) Team uses its daily team meeting to: (1) Conduct a brief, but clinically-relevant review of all clients & contacts in the past 24 hours AND (2) record status of all clients. Team develops a daily staff schedule for the day's contacts based on: (3) Weekly Client Schedules, (4) emerging needs, AND (5) need for proactive contacts to prevent future crises; (6) team members are held accountable for follow-through.	*Note tools used in daily team meeting and the quality of these tools. Does the team use a weekly client schedule to develop a daily staff schedule that is referred to within the meeting? Is someone documenting clients' status and contacts over the past 24 hours?*

Fidelity Scale Item	Reviewer Notes
OS2. Team Approach ACT staff work as a transdisciplinary team rather than as individual practitioners; ACT staff know and work with all clients. The entire team shares responsibility for each client; each clinician contributes expertise as appropriate.	*Observe how staff are scheduled to visit clients. Ideally, staff assignments will vary naturally as a consequence of scheduling daily services to meet the individual needs of each client; however, the team should also make an effort to diversify the staff scheduling to foster ongoing relationships between each client and several team members.*
CP2. Assertive Engagement Mechanisms The team uses an array of techniques to engage difficult-to-treat clients. These techniques include: (1) collaborative, motivational interventions to engage clients and build intrinsic motivation for receiving services from the team, and, where necessary, (2) therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to client or others. When therapeutic limit-setting interventions are used, there is a focus on instilling autonomy as quickly as possible. In addition to being proficient in a range of engagement interventions, (3) the team has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of chosen techniques, and modifying approach when indicated.	*Listen for clients staffed during team meeting who appear to be difficult to engage.* *Does the team set aside time to plan for how to work with these clients, even if this meeting occurs outside the daily team meeting?* *Does the team sound exceptionally heavy-handed in how they engage clients*?

Fidelity Scale Item	Reviewer Notes
EP6. Engagement & Psychoeducation with Natural Supports The FULL TEAM works in partnership with clients' natural supports. As part of their active engagement of natural supports, the team: (1) Provides education about their loved one's illness; (2) Teaches problem-solving strategies for difficulties caused by illness; and (3) Provides &/or connects natural supports with social & support groups.	*Listen for team members reporting on contacts with family and other natural supports. Do they reflect education, problem-solving strategies, and/or general support?*
EP7. Empirically-Supported Psychotherapy The team: (1) deliberately provides individual and/or group psychotherapy, as specified in the treatment plan; (2) uses empirically-supported techniques to address specific symptoms and behaviors; and (3) maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services. Ideally, psychotherapy is conducted by a trained therapist.	*Note whether team mental health therapists/clinicians identified report on specific psychotherapeutic techniques they are using with clients. Listen for any other team members who report on similar psychotherapy contacts.*
PP3. Interventions Target a Broad Range of Life Domains The team attends to a range of life domains (e.g., physical health, employment/ education, housing satisfaction, legal problems etc.) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in person-centered plans, and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs.	*Note the services and contacts planned for that day and the extent to which they reflect more than those typically clinically-defined (e.g., taking medications).*

Fidelity Scale Item	Reviewer Notes
PP4. Client Self-Determination and Independence The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.	*Observe the language used about clients in the daily team meeting. Note whether previous or planned contacts are directive in nature.*

ACT TREATMENT PLANNING MEETING OBSERVATION FORM

Program:	Date:
Reviewer:	

Fidelity Scale Item	Reviewer Notes
PP2. Person-Centered Planning The team conducts treatment planning according to the ACT model using a person-centered approach, including: (1) development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting); (2) conducting regularly scheduled treatment planning meetings; (3) attendance by key staff, the client, and anyone else they prefer (e.g., family), tailoring number of participants to fit with the client's preferences; (4) provision of guidance and support to promote self-direction and leadership within the meeting, as needed. For teams that use an ITT, treatment planning meetings should include members from this group. (5) treatment plan is clearly driven by the client's goals and preferences and is structured in a manner to inform person-centered practices.	

Other items to consider:

- How are strengths elicited and used during the development or revision of the treatment plan?
- If natural supports are not present, inquire into the reason behind their absence following the meeting.
- Did the team develop a weekly client schedule with the client during this treatment planning meeting, revise an existing weekly client schedule, or make a plan to meet to develop/revise a weekly client schedule that captures the changes to the treatment plan?
- Based on the assessment and chart information, were appropriate team members present at the meeting?

COMMUNITY VISIT OBSERVATION FORM

Program:	**Date:**
Reviewer:	

Fidelity Scale Item	**Reviewer Notes**
PP4. Client Self-Determination & Independence The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination. Observe the language staff use with the client. Attend to the degree to which staff is directive with client. How respectful are staff with client, especially when in client's natural environment? Do staff take liberties when in client's personal environment (e.g., looking in refrigerator without permission)? In general, to what degree do staff oversee the day-to-day activities of clients (e.g., what to wear, eat, do that day, etc.)? Does the level of supervision appear appropriate given client's level of functioning?	

Other areas to look out for:

- Evaluate both the type and quality of services provided.
    - Do they employ psychiatric rehabilitation or case management? Is the type of service appropriate for this/these particular client(s)?
    - How well are they providing other clinical services such as psychotherapy?
    - What is the quality of the integrated treatment for COD, EE, or wellness services delivered?

Team Name: _____ **Reviewer Name:** _____ **Selected 4-Week Period for Review:** _____

Unique Client ID: _____ **PSYCHIATRIC DIAGNOSES:** _____ **OS6. Diagnoses Fit with ACT admission criteria?** ☐ Yes ☐ No

DATE	Contact Location C = Community I = Institution[1] O = Office *(CP1)*	Team member/ Role *(OS2)*	Duration (min.) *(CP3)*	Briefly note content and quality of contact. Do not include contact attempts or contacts with collaterals in final tally, but information may be useful to track. Refer to CP1, CP3, and CP4 item guidelines to determine when to exclude a contact due to its questionable purpose and/or whether to collapse with another contact made on the same day.

Did Team say client is receiving this service from the team in **Excel Spreadsheet?**	Is this service **reported in progress note**? (if not, mark "no") **If yes**, distinguish the **quality of the service** (e.g., a high-quality service example is relatively detailed, reflects an active intervention, and generally in-line with the EBP; if the example practice is clearly misaligned with the EBP, also mark as "No" rather than as "low quality.")				**If yes,** does service appear to be **systematically provided**[2] in concordance with the definition of each service?		
☐ Yes	Integrated Treatment for Co-Occurring Disorders (Column B):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Employment & Educational Service (Column E):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Psychiatric Rehabilitation (Column J):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Manualized WMR Service (Column K):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Psychotherapy (Column M):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Healthcare/Lifestyle (Column N):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A

Please Note the Last Two Psychiatric Care Provider Visits: _____ _____ **Is most recent contact more than 3 months ago?** ☐ Yes

Psychiatric Resident visits may count here, but otherwise do not count if psychiatric care provider is not meeting team inclusion criteria (OS5 and CT3). Exception is if caseload responsibility is shared between one provider that does meet inclusion criteria with one psychiatric care provider who doesn't count.

Do you see evidence of brief therapy in Psychiatric Care Provider's notes? ☐ Yes ☐ No Note: _____

[1]**Institution** includes the following: hospital, jail, assisted living facilities, high supervision group homes, and other more restrictive settings. For sake of calculations, continue to treat those marked "community" and "institution" as both community contacts (not office). [2]**Systematically provided** = specialty practice occurs more than one time in 4-week period.

Team Name: _____ **Reviewer Name:** _____ **Selected 4-Week Period for Review:** _____

DATE	Contact Location C = Community I = Institution O = Office *(CP1)*	Team member/ Role *(OS2)*	Duration (min.) *(CP3)*	Briefly note content and quality of contact. Do not include contact attempts or contacts with collaterals in final tally. Refer to CP1, CP3, and CP4 item guidelines to determine when to exclude a contact due to its questionable purpose and/or whether to collapse with another contact made on the same day.

Team Leader Notes (total count; CT2)	Co-Occurring Disorder Specialist Notes (count; ST1)	Employment Specialist Notes (count; ST4)	Peer Specialist Notes (count; ST7)
All notes (count):	All notes (count): Specialist-related notes (count):	All notes (count): Specialist-related notes (count)	All notes (count): Specialist-related notes (count):

CHART REVIEW LOG (Part II). Partial Sample (i.e., 6 clients). TEAM_____ Client ID_____ Reviewer Name_____

ST2. COD & MH Assessments CLIENT INDICATED AS HAVING A SA DIAGNOSIS? ☐Yes ☐ No (if team didn't indicate, but other data sources clearly indicates, mark "yes")

Assessments Exist?	**Assessment Quality?**	**Stages of Change Readiness?**	Any **additional observations** regarding substance use assessments reviewed (e.g., timeliness, quality of the assessments) or assessment of stages of change readiness?
Intake? ☐Yes ☐ No Embedded in broader assessment or stand-alone? **Ongoing?** ☐Yes ☐ No Embedded in broader assessment or stand-alone? _____ Most recent date of ongoing assessment: _____ Who Completed Assessment? _____	Does the assessment examine the <u>interrelationship</u> between substance use and mental health symptoms and behaviors? ☐Yes ☐ No How would you rate the quality of the content captured in the Substance Use assessment? ☐low ☐moderate ☐high	Documentation of Stages of Change Readiness or Treatment anywhere in the chart? ☐Yes ☐ No (Where? _____) Does the completion of Stages of Change Readiness or Treatment assessment appear routine and updated (i.e., you see more than one assessment for a given client)? ☐Yes ☐ No Did the Stages of Change for this client appear to align with treatment strategies being used by the COD specialist? ☐Yes ☐ No ☐Unsure	

ST5. Employment and Education Assessment CLIENT INDICATED AS RECEIVING ANY EMPLOYMENT/EDUCATIONAL SERVICES? ☐Yes ☐ No (If no, skip this section)

Assessments Exist?	Is the assessment being used the IPS Career Profile* or a close version of the Career Profile? ☐Yes ☐ No How would you rate the quality of the content captured in the assessment? ☐low ☐moderate ☐high Does the assessment appear to be updated and used for the purpose of job search and ongoing supports? ☐Yes ☐ No See a copy of Career Profile here for reference: https://www.ipsworks.org/resources/programs/program-tools/	Any **additional notes** about the employment assessment, such as whether Career Profile is used to seek good job matches, provide follow-along supports, when it is being completed (ideally, it is completed when someone voices interest in work)?	**Other Assessments** **Other Assessments Observed** (e.g., Nursing, Functional Skill Assessment, Violence Risk Assessment):
Intake? ☐Yes ☐ No Embedded in broader assessment or stand-alone? _____ **Ongoing?** ☐Yes ☐ No Embedded in broader assessment or stand-alone? Most recent date of ongoing assessment: _____ Who Completed Assessment? _____			

OS4. Daily Team Meeting: Client Schedules (criterion #3). Examine whether the client schedule serve as a functional bridge between plans and what is being delivered. Summarize what is observed - are they formatted so that they can be shared with the client; are they organized by week or month; what level of detail is included in who (staff), when (day, even time of day), and why (intervention) the client is being seen?

PP1. Strengths Inform Planning				**CP6. Crisis Planning**
Rate the extent to which documented strengths and resources are both personal and rich in quality:[1] ☐ Poor ☐ Moderate ☐ Good ☐ No Strengths Assessed	List examples of documented strengths and resources:	Do you see evidence of strengths and resources informing the development of action steps and/or interventions within the plan itself? (e.g., if a person is noted to be artistic, is there deliberate effort to draw upon this when addressing other needs or challenges in the plan?) ☐ Yes ☐ No	(If Marked "Yes" in previous column:) List examples of how strengths/resources informed planning:	How well does the crisis plan appear to capture practical and individualized crisis planning information, including signs of increased distress or illness, options for how to best address emerging crisis? ☐ Poor ☐ Moderate ☐ Good ☐ No Crisis Plan

PP2. Person-Centered Planning			
Two most recent plan dates: _____ _____ Revisions or Addendum Dates: _____	Write down example Recovery or Long-Term goal from this plan	Write down example Short-Term goals/Objectives from this plan	Indicate other observations of the plan itself, such as the overall flow of the plan -- do interventions relate (upstream) to objectives/goals? Do objectives/short-term goals logically relate to the long-term/recovery goal? Are interventions personalized, relatively specific, and reflect what the team is going to do (not the client)? Do the plans appear to follow from a person-centered process?

PP3. Interventions Target a Broad Range of Life Domains. Assess the extent to which planned and delivered interventions target a broad range of life domains. We are interested in **life domains** other than medication management and symptom monitoring. For criterion A, refer to planned interventions not the goals. For criterion B, do not include documented passive observations, such as "presented with poor hygiene," as an intervention.

Life Domains:	**PP3. Criterion A**	**PP3. Criterion B**	**PP3. Criterion C**
1) Distressing symptoms and/or challenging behaviors addressed by psychotherapy 2) Employment and Education 3) Healthcare management and prevention (this includes dental) 4) Housing access and resources 5) Family Relationships 6) Finances/Budgeting 7) Functional daily living skills - household maintenance 8) Functional daily living skills - self-care (e.g., grooming, hygiene) 9) Functional daily living skills—social/interpersonal skills, leisure, and/or mobility 10) Legal aid and supports 11) Psychoeducation for symptom management 12) Relapse prevention for mental health symptoms (using WMR) 13) Substance use	**Life domains** that were addressed with a planned intervention **in the person-centered plan** (list numbers from previous column):	**Life domains** that were addressed with an intervention, per the reviewed **progress notes** (list numbers from previous column)**:**	Are at least 50% of the planned interventions (A) present in delivered interventions (B), indicating alignment?" ☐Yes ☐ No

[1] "Good quality" examples would list at least eight personal strengths, e.g., has a great sense of humor, is attentive to details, completed High School, has a supportive family, takes good care of her dog. "Good patient" attributes, such as "engaged in treatment and takes medications," should not receive credit.

CHART REVIEW TALLY SHEET (Part I) – Tally list of 20% (minimum of 10) client charts.

***Reminder: Only count toward these items those face-to-face client contacts made by staff who met ACT team inclusion guidelines (See OS1 and OS5; e.g., exclude staff who work less than 16 hours with the team). Review each Chart Review Log PT I to exclude non-ACT staff before tallying data here. Also, for OS2 and CP1, only consider those charts with at least one contact.

Unique Client ID	OS2: Team Approach	OS6. Priority Service Population	CT4. Psychiatric Provider Contacts (and CP7)	CP1: Community-Based Services	CP3: Intensity of Service	CP4: Frequency of Contact	CT7, CP8, EP1 - EP3 Full Responsibility for Service Items, and EP7					
							For each chart, code the following:					
	Total # of ACT team members in contact with client during a 4-week period (*DACTS Standard is more than 1 team member in first 2 weeks)	Does diagnosis fit w/ ACT criteria? If not, note diagnosis.	How often seen by ACT psychiatric care provider?[1] Code: **1** = within 6 weeks **2** = within 3 months **3** = 3+ months (add * if therapy)	**% of total** contacts that are community-based (collapse "community" and "institution" together) (Total # face-to-face community-based contacts/Total # of face-to-face office & community-based contacts)	**Mean/ average #** of minutes per week over 4-week period (Total minutes/4)	***Mean/average #*** of face-to-face contacts (office and community) per week over 4-week period	+ = If indicated by team as receiving this Service (Excel Spreadsheet)		H = Evidence of Higher Quality best practice services L = Evidence of Lower Quality best practice services		* = If service systematically provided (i.e., there is a deliberate pattern of service delivery).	
							Integrated Tx for Co-Occurring Disorders (EP1)	SEE services (EP2)	Psych Rehab Services (CP8)	WMR Services (EP3)	Psycho-therapy (EP7)	Health (CT7)
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
11.												
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18.												
19.												
20.												
21.												
22.												
23.												
24.												
25.												
26.												
27.												
28.												
29.												
30.												

Final Calculations	**OS2: Team Approach** For those with at least 1 face-to-face contact, total # of clients with contacts with at least 3 team members/# of client charts reviewed. _____ % Ex. Of 20 charts reviewed, 2 charts did not have any contacts that month. Of the 18 charts with at least 1 face-to-face contact, 14 saw at least 3 staff in 4 weeks. 14/18 = 78%.	**OS6: Priority Service Pop.** Total % of charts (# of "yes" / total # charts with data inputted) _____ % Ex. Of 16 charts reviewed, data were entered for 15 charts (one was missing this data point). Of the 15 with diagnoses reviewed, 13 were judged to meet criteria. 13/15 = 87%	**CT4. Psych Care Provider** Total % of charts meeting "1" criteria (6 weeks or less): _____ % Total % of charts meeting "2" criteria (seen within 3 months): _____ % Total % of charts meeting "3" criteria (seen outside of 3 months): _____ % **% Therapy**_____	**CP1: Community-Based** Median Value = when rank-ordered, average between middle two values or middle value if odd # of charts. Be sure to only include those charts that had at least 1 face-to-face contact in 4-week period. **Median**_____ Ex. Of 20 charts reviewed, 2 charts did not have any contacts that month. Of the 18 charts with at least 1 face-to-face contact, the median percent (i.e., average of Chart #9 (90%) and Chart 10 (100%) when rank-ordered was 95%.	**CP3: Intensity** Median Value = when rank-ordered, average between middle two values or middle value if odd # of charts. All charts are included (i.e., those with no contacts are included). **Median:** _____ Ex. Of 20 charts reviewed and rank-ordered from lowest to highest, the median Intensity (i.e., average of Chart #9 (30 mins) and Chart 10 (40 mins)) when rank-ordered was 35 mins. TIP: Enter total minutes per chart into the tally, identify the median intensity and then divide by 4 to calculate the weekly rate used to rate CP3.	**CP4: Frequency** Median Value = when rank-ordered, average between middle two values or middle value if odd # of charts. All charts are included (i.e., those with no contacts are included). **Median:** _____ Ex. Of 20 charts reviewed and rank-ordered from lowest to highest, the median number of contacts (i.e., average of Chart #9 (1.5/wk) and Chart 10 (2/wk)) when rank-ordered was 1.75/week. TIP: Enter total number of contacts per chart into the tally, identify the median frequency and then divide by 4 to calculate the weekly rate used to rate CP4.

Item/Service Type	Method 1			Method 2		
	% of all charts coded with an H (high quality) OR L (low quality)	% of charts indicated as receiving service from team (+) coded with an H (high quality) only	% of charts indicated as receiving service from team (+) coded with (*) as systematic	% of charts indicated as receiving service from team (+) coded with an H (high quality) OR L (low quality)	% charts indicated as receiving service from team (+) coded with an H (high quality) only	% of charts indicated as receiving service from team (+) coded with (*) as systematic
EP1. Integrated Treatment for Co-Occurring Disorders						
EP2. Employment and Educational Services:						
CP8. Psychiatric Rehab Services						
EP3. WMR Services						
EP7. Psychotherapy**						
CT7. Health						

[1]For CT4, examine the timespan between the last two provider face-to-face contacts and consider the appropriate rating: If the timespan is more than 3 months, code it as a "3" (3+ months); if between 7 weeks up to 3 months, code as a "2," and if 6 weeks or less, code as a "1."

Also consider the timespan between the date of the TMACT review and the most recent face-to face contact. If there is significant lapse of time without a documented contact (more than 3 months), adjust the code to a "3" (see examples F and G in the following Table, where the timespans were within 2 months and within 6 weeks, respectively, but the most recent date as more than 3 months ago).

Ex.	Evaluation Date	Most Recent Psych Provider F-to-F Note Date	2nd Most Recent Psych Provider Note Date	Coding
A	Sept 1,2017	July 28th, 2017	June 7th, 2017	1
B	Sept 1,2017	August 21st, 2017	May 30th, 2017	2
C	Sept 1,2017	July 2nd, 2017	May 19th, 2017	1
D	Sept 1,2017	July 2nd, 2017	April 24th, 2017	2
E	Sept 1,2017	August 21st, 2017	March 1, 2017	3
F	Sept 1,2017	May 28th, 2017	March 25th, 2017	3
G	Sept 1, 2017	May 28th, 2017	May 1st, 2017	3

Please refer to TMACT Calculation Workbook to enter data for final calculations for OS2 and OS6 above.

Chart Review Tally Sheet (Part II) – Partial Sample (i.e., 6 charts). TEAM: _____

Co-Occurring Disorders (COD) Assessments (ST2)

Client ID	SA Indicated by Team?	Summarize the following (across the 6 charts, and/or those indicated as having SA): 1) What is observed at **intake** (quality (i.e., examine interrelationship), timelines, who is completing); 2) What is observed for **ongoing (COD) assessments** (quality (i.e., examine interrelationship), timelines, who is completing); 3) **Stages of Change** Readiness and Treatment assessed? (indicate where, if appearing accurate, updated); and 4) Any notable **other observations** related to assessment and treatment of CODs?

Employment and Education Assessment (ST5)

Client ID	EE Services Indicated by Team?	Summarize the following (across the 6 charts, and/or those indicated as receiving EE Services): 1) What is observed at **intake** (quality, timelines, who is completing); 2) What is observed for **ongoing EE assessments** (i.e., examine quality, timelines, who is completing); 3) Any evidence suggesting the EE assessment is being used to **guide job placement and supports**; and **4)** Any notable **other observations** related to EE assessment and services

Client Schedules (OS4)

Summarize Client Schedules **(OS4)** To what extent is the client schedule: 1) detailed; 2) derived from planned interventions; and 3) appears to inform what is scheduled out each day in team meeting)?

Chart Review Tally Sheet (Part II) – Partial Sample (i.e., 6 charts). TEAM: _____

Co-Occurring Disorders (COD) Assessments (ST2)

Client ID	SA Indicated by Team?	Summarize the following (across the 6 charts, and/or those indicated as having SA): 1) What is observed at **intake** (quality (i.e., examine interrelationship), timelines, who is completing); 2) What is observed for **ongoing (COD) assessments** (quality (i.e., examine interrelationship), timelines, who is completing); 3) **Stages of Change** Readiness and Treatment assessed? (indicate where, if appearing accurate, updated); and 4) Any notable **other observations** related to assessment and treatment of CODs?

Employment and Education Assessment (ST5)

Client ID	EE Services Indicated by Team?	Summarize the following (across the 6 charts, and/or those indicated as receiving EE Services): 1) What is observed at **intake** (quality, timelines, who is completing); 2) What is observed for **ongoing EE assessments** (i.e., examine quality, timelines, who is completing); 3) Any evidence suggesting the EE assessment is being used to **guide job placement and supports;** and 4) Any notable **other observations** related to EE assessment and services

Client Schedules (OS4)

Summarize Client Schedules **(OS4)** To what extent is the client schedule: 1) detailed; 2) derived from planned interventions; and 3) appears to inform what is scheduled out each day in team meeting)?

Chart Review Tally Sheet (Part 3). Calculating the Use of Staff within their respective Roles (see Chart Log I)

ITEM	Team Member (insert name)	(A) Total # of Note Entries Across all charts	(B) Total # of Specialty-Related note entries	Percent of Note Entries with a service reflecting area of specialty (B/A).
CT1 and CT2	Team Leader:		n/a	n/a
ST1	COD 1:			
	COD 2:			
ST4	Emp Spec 1:			
	Emp Spec 2:			
ST7	Peer Spec 1:			
	Peer Spec 2:			

Cross-walk reported and observed time spent in specialist services (e.g., what percent of progress note entries by co-occurring disorders specialist have some notation of integrated treatment for co-occurring disorders, inclusive of assessment and engagement, which may not be overtly documented?).

Significant discrepancies may warrant an adjustment from what was reported given what was observed in the chart (e.g., specialist reports 90%, and chart review data finds only 50%; with this example, and depending on what other data sources indicate (e.g., scheduling practices), reducing to 70% may be a more accurate reflection of how the specialist is used in his or her role. As you only have data from a 20% sample and lack information to know how representative the dataset is for that given specialist, use chart data judiciously when adjusting reported percentages, and consider other sources (team scheduling practices, overall competency of specialist (if they clearly do not understand their area of specialty, it is more difficult to make a case that they are used in their specialty role, many observed missed opportunities to use the specialist)

Fidelity & Quality Improvement: Applications of the TMACT

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27th Annual Assertive Community Treatment Conference
Chicago, IL
June 18, 2010

Overview of Today's Presentation

1. What is fidelity and why does it matter?
2. DACTS to TMACT: How did we get here and what was changed?
3. Overview of the TMACT
4. Pilot studies of TMACT reliability and validity
5. Applying the TMACT for QI purposes in several states
6. Re-examining the relationship between fidelity and outcomes
7. Conclusions & next steps

Program Fidelity

What is it & why does it matter?

Fidelity: An overview

- Definition: The degree to which a program includes features that are critical to achieving the intended outcomes
- Many purposes of fidelity measures
  - Our focus: To guide quality improvement efforts
- Fidelity is positively correlated with outcomes
  - More cost-effective (Latimer, 1999)
  - Decreases hospital days (McHugo et al., 1999)
- Provides a conceptual base for informed adaptation and innovation

Dartmouth ACT Scale (DACTS)

(Teague, et al., 1998)

- Most widely used ACT fidelity measure
- 28 items/ 5-point anchored scales
  - (1 = not implemented; 5 = fully implemented)
- 3 subscales (structure informed by McGrew et al., 1994)
  - Human Resources
  - Organizational Boundaries
  - Services
- Incorporated into Evidence-Based Practices (Toolkit) Project
- Sometimes used for accreditation/funding

Example DACTS Item: O4. Responsibility for Crisis Services

Domain	Rating				
	1	2	3	4	5
Responsibility for Crisis Services	Not responsible for handling crises after hours	Emergency service has program-generated protocol	Program available by phone; consult role	Program provides emergency service backup	Program provides 24-hour coverage

DACTS Concerns

- Original intent: multi-site study of ACT for COD
- No ACT program manual available when developed
- Little grounding in program theory
- Doesn't fully match up with the National ACT Standards
- Focus is on structure vs. process
- Specific measurement gaps:
  - Recovery-oriented practices (vs. medical model)
  - Team functioning (vs. team structure)
  - Staff roles (e.g., vs. staff FTE)
  - Specific treatment & rehabilitation interventions
  - Recalibration of some items

From DACTS to TMACT

How did we get here (TMACT) from there (DACTS)?

Washington State ACT Implementation

- WA richly funded 10 ACT teams in 2007
- WA chose & adapted National ACT Standards
- Needed to address concerns about a potentially coercive or paternalistic model
- Rich training & TA with focus on:
  - Promoting a culture of recovery within teams on Day 1
  - Getting ACT basics down, but quickly moving to clinical skill-building (e.g., MI, IDDT, SE)
- Speaks to need for a fidelity tool that captures these essential processes
- Implications outside of WA State

Our approach to scale development

- Applied the DACTS template & approach
- Crosswalked WAACT Standards with DACTS
- Built on the initial work of ACT Center of Indiana
- Worked collaboratively with national experts on core content development
- Ongoing Vetting & Feedback:
  - Practicing ACT clinicians
  - National experts in related areas
  - Fidelity reviewers who piloted the scale
  - Interested & future pilot sites
- Piloted 52-item version with 2 WA teams; refined through further piloting in WA, PA, NY, NE, & FL

Our Aims

- Better assess processes consistent with high fidelity ACT
  - Recovery-oriented services
  - Evidence-based practices
  - Functions promoting a transdisciplinary team
- Improve the reliability and validity of the assessment
  - Minimize subjectivity
  - Offer more guidance with concrete examples and decision rules
- Create a more nuanced measure of ACT
  - Distinguish between low, moderate, and high fidelity ACT teams

The Tool for Measurement of ACT (TMACT)

What did we change & why?

From DACTS to TMACT: Changes

DACTS = 28 items

- Revised (20 items)
  - Rescaled anchors
  - Modified assessment
- Removed (6)
  - Items not particular to ACT
  - Folded into another
- Added (25)
  - New items judged critical to ACT
  - Extracted/ expanded concepts embedded in earlier items

TMACT = 47 items

Summary of Items Added

- **Evidence-based practices**
  - ACT is a platform for delivering comprehensive services
  - Many effective services available for adults with severe mental illness
- **Staffing roles <u>in treatment</u> and <u>within team</u>**
  - A warm, qualified body not enough!
  - More specification about what services are to be delivered
  - Creating a true transdisciplinary team
- **4 items assessing person-centered planning practices**
  - If misused, ACT services have the potential for being coercive and paternalistic.
  - Operating from a recovery model arguably epitomizes high fidelity ACT

The Tool for Measurement of ACT (TMACT)

What does it look like?

Overview of the TMACT

- 47 items; 5-point anchored scales
- 6 subscales:
  1. Operations & Structure (OS): *12 items*
  2. Core Team (CT): *7 items*
  3. Specialist Team (ST): *8 items*
  4. Core Practices (CP): *8 items*
  5. Evidence-Based Practices (EP): *8 items*
     - Includes 1 Supportive Housing item under development
  6. Person-Centered Planning Practices (PP): *4 items*

Operations & Structure (OS)

- OS1. Low Ratio of Consumers to Staff
- OS2. Team Approach
- OS3. Daily Team Meeting (Frequency & Attendance)
- OS4. Daily Team Meeting (Quality)
- OS5. Program Size
- OS6. Priority Service Population
- OS7. Active Recruitment
- OS8. Gradual Admission Rate
- OS9. Graduation
- OS10. Retention Rate
- OS11. Coordination of Hospitalization
- OS12. Dedicated Office-Based Program Assistance

OS4. Daily Team Meeting (Quality): Team uses its daily team meeting to: (1) Conduct a brief, but clinically-relevant review of all consumers & contacts in the past 24 hours AND (2) record status of all consumers. Team develops a Daily Staff Assignment Schedule for the day's contacts based on: (3) Weekly Consumer Schedules, (4) emerging needs, AND (5) need for proactive contacts to prevent future crises; (6) Staff are held accountable for follow-through.

1	2	3	4	5
Daily team meeting serves no more than 1 function OR 2 functions served, at least PARTIALLY.	Meeting FULLY serves 2 functions OR 3 functions served, at least PARTIALLY.	Meeting FULLY serves 3 functions OR 5 functions served, at least PARTIALLY.	Meeting FULLY serves 4 or 5 of the functions.	Daily team meeting FULLY serves ALL 6 functions (see under definition).

Core Team (CT)

- CT1. Team Leader on Team
- CT2. Team Leader is Practicing Clinician
- CT3. Psychiatric Care Provider on Team
- CT4. Role of Psychiatric Provider (In Treatment)
- CT5. Role of Psychiatric Provider (Within Team)
- CT6. Nurses on Team
- CT7. Role of Nurses

CT4. Role of Psychiatric Care Provider (In Treatment): In addition to providing psychopharmacologic treatment, the psychiatric care provider serves the following functions in TREATMENT: (1) typically meets with consumers at least monthly to conduct assessment of consumers' symptoms & response to medications, including side effects; (2) provides brief therapy; (3) provides medication education to consumers; (4) monitors all consumers' non-psychiatric medical conditions and non-psychiatric medications; (5) if consumers are hospitalized, communicates directly with consumers' inpatient psychiatric care providers to ensure continuity of care; & (6) conducts home/community visits.

1	2	3	4	5
Psychiatric care provider performs no more than 2 functions total.	Psychiatric care provider performs 3 or 4 functions.	Psychiatric care provider performs 4 functions, which include function #1 OR performs 5 functions (#2 - #6).	Psychiatric care provider performs 5 functions, which includes function #1.	Psychiatric care provider performs ALL 6 treatment functions (see under definition).

CT5. Role of Psychiatric Care Provider (Within Team): 1) supervises the psychiatric treatment of consumers on the team; (2) educates non-medical team members on medications and their side effects; (3) attends majority of treatment planning meetings; (4) attends daily team meetings in proportion to time allocated on team; (5) actively collaborates with RNs; and (6) provides psychiatric back-up to the program after-hours and weekends.

1	2	3	4	5
Psychiatric care provider performs no more than 2 team functions.	Psychiatric care provider performs 3 team functions.	Psychiatric care provider performs 4 team functions.	Psychiatric care provider performs 5 team functions. If two providers, ONE must perform these 5 team functions & there is a mechanism for communication between providers.	Psychiatric care provider performs ALL 6 team functions. If two providers, ONE must perform all 6 team functions & there is a mechanism for communication between providers.

Specialist Team (ST)

- ST1. Substance Abuse Specialist on Team
- ST2. Role of SA Specialist (In Tx)
- ST3. Role of SA Specialist (Within Team)
- ST4. Vocational Specialist on Team
- ST5. Role of Voc Specialist (In Employment Services)
- ST6. Role of Voc Specialist (Within Team)
- ST7. Peer Specialist on Team
- ST8. Role of Peer Specialist

ST8. Role of Peer Specialist: (1) coaching and consultation to consumers to promote recovery and self-direction (e.g., preparation for role in treatment planning meetings); (2) facilitating wellness management strategies (e.g., WRAP, IMR); (3) full participation in all team activities (e.g., tx planning, chart notes); and (4) cross-training of other team members in recovery principles and strategies.

1	2	3	4	5
No Peer Specialist staffing on team OR Peer Specialist does not perform any of the 4 functions within the team.	Peer Specialist FULLY performs 1 function within the team OR 2 functions, at least PARTIALLY.	Peer Specialist FULLY performs 2 functions within the team OR 3 – 4 functions, at least PARTIALLY.	Peer Specialist FULLY performs 3 functions within the team.	Peer Specialist FULLY performs ALL 4 functions within the team (see under definition).

Core Practices (CP)

- CP1. Community-Based Services
- CP2. Assertive Engagement Mechanisms
- CP3. Intensity of Service
- CP4. Frequency of Contact
- CP5. Freq. of Contact with Natural Supports
- CP6. Responsibility for Crisis Services
- CP7. Full Responsibility for Psychiatric Services
- CP8. Full Responsibility for Rehab Services

CP8. Full Responsibility for Rehabilitative Services: Rehab. services are directly provided by the ACT team rather than by an external program or provider. These services include: social & communication skills training, functional skills training to enhance independent living (e.g., activities of daily living, meals, safety, planning, chores), transportation planning/navigation skill building, & money management.

1	2	3	4	5
Less than 30% of consumers in need of rehabilitation services are receiving them from the team.	30 - 59% of consumers in need of services are receiving them from the team.	60 - 79% of consumers in need of services are receiving them from the team.	80 - 89% of consumers in need of services are receiving them from the team.	90% or more of consumers in need of rehabilitation services are receiving them from the team.

Evidence-Based Practices (EP)

- EP1. Full Responsibility for DD Services
- EP2. Full Resp. for Vocational Services
- EP3. Full Resp. for Wellness Management
- EP4. Integrated Dual Disorders Tx Model
- EP5. Supported Employment Model
- EP6. Engagement & Psychoeducation w/ Natural Supports
- EP7. Empirically-Supported Psychotherapy
- EP8. Supportive Housing Model (new!)

EP4. Integrated Dual Disorders Tx (IDDT) Model: The FULL TEAM (1) considers interactions between mental illness and substance abuse; (2) follows cognitive-behavioral principles; (3) does not have absolute expectations of abstinence and supports harm reduction; (4) understands and applies stages of change readiness in treatment; and (5) is skilled in motivational interviewing.

1	2	3	4	5
Team primarily uses traditional model. (e.g., 12-step programming, focus on abstinence). Criteria not met.	Only 1 - 2 criteria are met.	Only 3 criteria are met.	Team primarily operates from IDDT model, meeting 4 criteria.	Team is FULLY based in IDDT treatment principles and meets all 5 criteria (see under definition).

EP6. Engagement & Psychoeducation with Natural Supports: The FULL TEAM works in partnership with consumers' natural supports. As part of their active engagement of natural supports, team (1) provides education about their loved one's illness; (2) teaches problem-solving strategies for difficulties caused by illness; and (3) provides &/or connects natural supports with social & support groups.

1	2	3	4	5
Team does not use any of the specified strategies with consumers' natural supports.	Team uses 1 or 2 specified strategies with consumers' natural supports.	Team uses 3 specified strategies with consumers' natural supports, but 2 strategies are only PARTIALLY provided.	Team uses 3 specified strategies with consumers' natural supports, but 1 strategy is only PARTIALLY provided.	Team works in partnership with consumers' natural supports and engages them using ALL 3 strategies (see under definition).

Person-Centered Planning Practices (PP)

- PP1. Strengths Inform Treatment Plan
- PP2. Person-Centered Planning
- PP3. Interventions Target a Broad Range of Life Goals
- PP4. Consumer Self-Determination & Independence

PP2. Person-Centered Planning: Includes: (1) development of formative treatment plan ideas based on initial inquiry and discussion with consumer; (2) conducting regular treatment planning meetings; (3) attendance by key staff, consumer, & anyone else s/he prefers, tailoring number of participants to fit with the consumer's preferences; (4) meeting is driven by consumer's goals & preferences; & (5) provision of coaching & support to promote self-direction and leadership within the meeting, as needed.

1	2	3	4	5
Team provides no more than 1 element of person-centered planning OR 1 element provided, at least PARTIALLY.	Team FULLY provides 2 elements of person-centered planning OR 2 elements provided, at least PARTIALLY.	Team FULLY provides 3 elements of person-centered planning OR provides 4 elements, at least PARTIALLY.	Team FULLY provides 4 elements of person-centered planning.	Team FULLY provides ALL 5 elements of person-centered planning (see under definition).

TMACT Protocol: This is the scale!

- Part I: Introduction
  - Checklists to prepare for fidelity reviews
  - Methods
  - Reporting guidelines
- Part II: Item-by-item breakdown
  - Data sources
    - Specific interview questions
    - What to look for within each data source
  - Guidelines for scoring
    - Explicit inclusion & exclusion criteria
    - Tables & checklists
    - Case examples
    - Formulae for ratings
- Part III: Appendices
  - All additional forms

Chart review forms, etc.

OS1. Low Ratio of Consumers to Staff : Team maintains a low consumer-to-staff ratio of 10:1, including all direct service staff.					
DATA SOURCES					
Team Survey:	See item #2: # of full-time ACT staff. See item #8: # of consumers presently served				
ITEM RESPONSE CODING					
Inclusion Criteria:	❑ ***ACT Staff:*** Count all staff who provide direct services (substance abuse specialist, vocational specialist, and team leader) EXCEPT the psychiatric care provider. Part-time or temp staff must work exclusively with the team for at least 16 hrs/wk & attend the daily team meeting at least 2x per week. ❑ ***Consumers:*** In counting the current caseload, include all "active" or "enrolled" consumers. The caseload totals should include any consumer who has been formally admitted, even if it is as recent as the last week. This count should not exclude consumers currently enrolled on the team who are difficult to engage and have not had recent contact with the team. 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.				
Exclusion Criteria:	❑ Do not include psychiatric prescriber in count. ❑ Do not include administrative support staff, such as the program assistant or other managers assigned to provide administrative oversight to the team. ❑ Do not count staff who are technically employed by the team but who have been on extended leave for 3 months or more.				
Formula:	(# CONSUMERS PRESENTLY SERVED) / (# FTE STAFF)				
OS1. Low Ratio of Consumers to Staff	**1**	**2**	**3**	**4**	**5**
	26 consumers per team member or more.	19-25	14 - 18	11 -13	10 consumers per team member or fewer.

ST3. Role of Substance Abuse Specialist (Within Team): Substance abuse specialist serves the following functions WITHIN THE TEAM: (1) modeling skills & individual consultation; (2) cross-training other team members to help them identify substance use issues, monitor progress in treatment, & provide stage-wise treatment for dual disorders; (3) attending all daily team meetings; & (4) attending all treatment planning meetings for consumers with dual disorders.					
DATA SOURCES (* Denotes primary data source)					
Substance Abuse Specialist Interview*	*How often do you attend the daily team meetings?* *Do you ever attend treatment planning meetings for the consumers? How do you select the ones you attend?* *Have you provided more formal trainings on assessment and stage-wise treatment interventions to the team? When, how often, what was the topic?* *Do you ever provide more individual consultation with team members?* Ask for an example.				
Clinician Interview:	*How has your work with consumers been influenced by the substance abuse specialist?*				
ITEM RESPONSE CODING					
General Frequency Guidelines:	❑ **Cross-training:** Provided in the past 6 months ❑ **Consultation:** Provided at least monthly ❑ **Attendance at Daily Team Meetings:** Evidence that there is regular attendance at all daily team meetings (except pre-planned activities that conflicted with meeting). ❑ **Attendance at Treatment Planning Meetings:** Attendance at vast majority of treatment planning meetings for consumers with dual disorders.				
Rating Guidelines:	Use interview with the substance abuse specialist as primary data source. Cross-reference with interview with clinician. Reconcile any discrepancies with follow-up questions with team leader.				
	1	**2**	**3**	**4**	**5**
ST3. Role of Substance Abuse Specialist (Within Team)	No substance abuse specialist staffing on the team OR does not perform any of the 4 functions.	Substance abuse specialist PARTIALLY performs 1 or 2 functions within the team.	Substance abuse specialist performs 2 functions within the team.	Substance abuse specialist performs 3 functions within the team.	Substance abuse specialist performs ALL 4 functions within the team.

OS9. Graduation	
Criteria	**Guidelines & Examples**
(1) Team conducts regular assessment of need for ACT services	❑ Team members regularly assess for readiness for graduation and improvement across all areas of clinical and role functioning. ❑ Team includes discussion about consumer's readiness for transition from ACT as part of their regular treatment plan reviews. ❑ Team may use a level of care system to categorize consumer readiness for discharge & regularly review as a team or ITT.
(2) Team uses explicit criteria or markers for need to transfer to less intensive option.	❑ Use of fewer or less intensive services such as hospitals or emergency rooms ❑ More independent functioning in major role areas (e.g., work, social, self-care)
(3) Transition is gradual & individualized, with assured continuity of care	❑ Gradual transition may begin with a "Transition Group," comprised of other ACT consumers who are getting ready for graduation. ❑ Consumer may try out services in another program for brief periods of time (e.g., a few hours or one day) while still receiving ACT services. ❑ Team should have some mechanism for communicating with transition service provider. ❑ Even when consumer transitions, there are mechanisms for him/her to contact the ACT team.

OS9. Open-Ended Services/Graduation (Continued)	
Criteria	**Guidelines & Examples**
(4) Status is monitored following transition, per individual need.	❑ Team continues to communicate with transition service provider regarding consumer's status. NOTE: These do not have to be formal meetings, but need to at least be some form of checking in on the consumer's status. ❑ If needed, team members visit consumer to assess status in transition services after graduation.
(5) There is an option to return to the team as needed.	❑ Team may reserve 1-2 slots for re-enrollment of consumers who graduate from the program for a limited period of time (e.g., 3 months post-discharge from ACT).

Examples of Stage-Wise Substance Abuse Treatment Interventions			
Early Stages of Change Readiness		**Later Stages of Change Readiness**	
Pre-Contemplation	**Contemplation and Preparation**	**Action**	**Maintenance**
Consumer does not recognize that s/he has a problem with substance use or has no interest in modifying use at this time. Focus of treatment is outreach, assessment, and building a working alliance. Services are provided regardless of ongoing use.	Consumer recognizes that substance use is causing some problems & is considering a change. ***Contemplation Stage:*** Consumer is more aware about the pros & cons, but ambivalent about change ***Preparation Stage:*** Consumer is *planning* for change. Focus of treatment is education about substances, mental illness, & their interactions, and identifying pros & cons of use. Motivational interviewing techniques : ❑ Express empathy ❑ Offer reflective listening ❑ Assist with goal-setting ❑ Develop discrepancy between goals & substance use ❑ Develop pros & cons ❑ Roll with resistance ❑ Emphasize personal choice	The consumer is committed to reducing or discontinuing substance use. Focus of treatment is helping her/him make change & sustain it: ❑ cognitive-behavioral therapy ❑ managing social environments ❑ identifying & managing triggers and cravings ❑ relaxation/coping skills ❑ money management to avoid using ❑ problem solving to reduce stress	The consumer has abstained from substance use for at least 6 months. Focus of treatment is maintaining abstinence: ❑ develop a relapse ❑ prevention plan ❑ help consumer attend ❑ self-help groups ❑ help build and maintain social supports for sobriety ❑ maintain awareness of vulnerability to relapse ❑ help expand recovery to other areas of life (parent group, vocational supports)

Fidelity Review Method

- Review in pairs of two; independent ratings & consensus on final team rating
- Currently takes 1.5 days per fidelity review
- Primary data sources:
  - Team survey & Excel spreadsheet (before review)
  - Observation of daily team meeting & treatment planning meeting
  - Chart review (random selection of 10)
  - Interviews with most staff
  - Interviews with consumers (3-5)
- Use enhanced protocol & data collection forms
- Feedback targets performance improvement

Training & Supervision of Reviewers

- Training on ACT – need to know the model! Train the Trainer
- Orientation to TMACT protocol
- Conduct evaluations
  - Sit in on 1-2 fidelity assessments, participating side-by-side with fidelity reviewers
  - Participate in consensus ratings during training
  - Team up with an experienced fidelity reviewer for first independent reviews
- Peer review of fidelity ratings & reports
  - Check accuracy of ratings and quality of item-level feedback
  - Provide coaching in how to synthesize data to make meaningful recommendations
- Maintaining and improving quality of evaluation process
  - Assessor training and work performance checklist (ACT Toolkit)
  - Booster training to prevent drift

Written Reports: Mastering the Skill of Providing Thoughtful Feedback

- Comprehensive written reports (20 – 30 pages)
  - Item level ratings with some feedback and rating justification
  - Synthesized feedback on the team's strengths and areas recommended for improvement.
- Feedback provided at both the macro and micro level
  - Review data to identify major themes that capture areas in need of improvement
  - Major areas of improvement may not be directly assessed by the TMACT, but if remedied, will have an impact across several items.

Examples of Major Themes from one report:

- Expand the scope of individualized, evidence-based services delivered to ACT consumers
- Refocus team member's efforts towards the consumers who would benefit most from their particular area of expertise and/or therapeutic relationship.
- Develop greater team cohesion so that the full array of team resources are being accessed, and team members' practice philosophies both compliment and correct one another.

Written Reports: Mastering the Skill of Providing Thoughtful Feedback

Example of micro-level feedback subsumed under major theme:

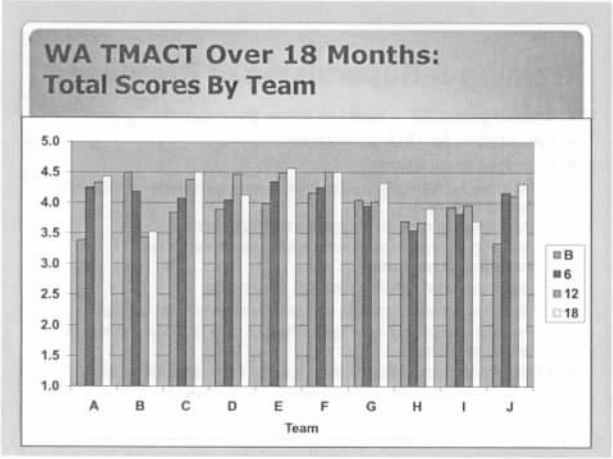
- We recommend re-evaluating the use of Wednesday afternoons for paperwork days for all staff.
  - A system can be created where staff request paperwork time when it becomes more pressing for them to have it.
  - A rotating shift management role can also provide time for staff to get caught up on paperwork.
  - If a large part of paperwork demands center on developing plans, then try to fully utilize the ITTs to meet for an hour weeks before a plan is due, to sketch out the plan given conversations they'd had with consumer leading up to this point. The meeting with the consumer then becomes more a review, where the consumer modifies the tentative plan already drafted. This process tends to reduce burden for the primary care coordinator for that consumer.

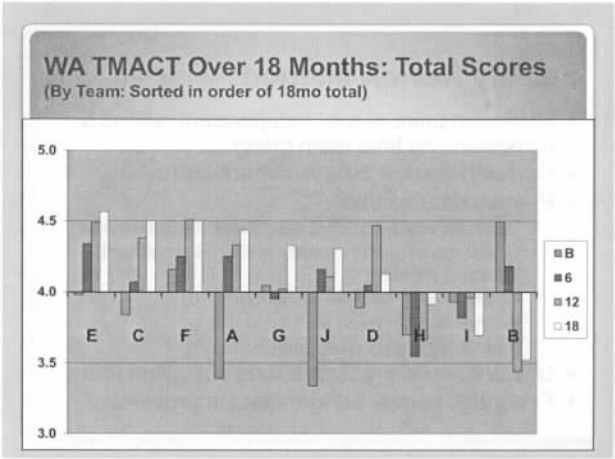
Piloting the TMACT

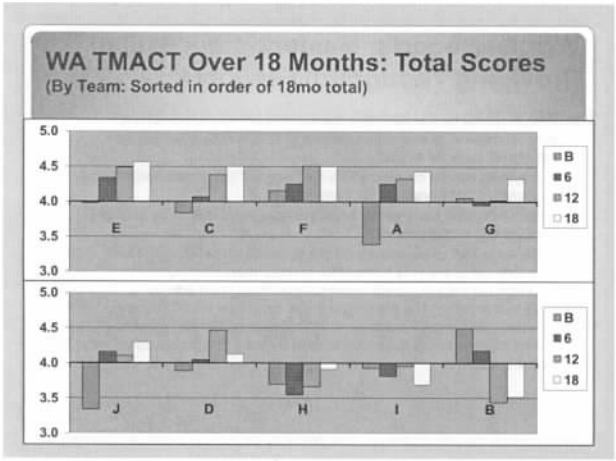
What have we found so far?

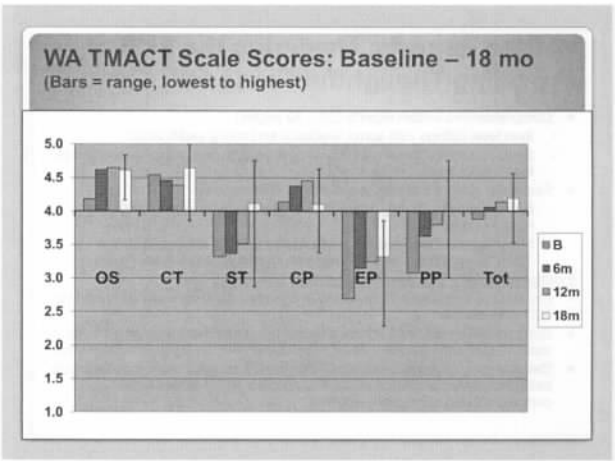
Method

- Fidelity reviews with TMACT in three states:
  - WA: 10 teams at baseline, 6m, 12m, 18m
  - PA (Allegheny Co): 6 teams at one point in time (analyzed at various stages/ages of implementation)
  - NY: 49 teams at one point in time (analyzed at various stages/ages of implementation)
- Similar approaches to data collection, using at least two fidelity reviewers per site
- WA & PA reviews took 1½ days; NYS reviews took 1 day









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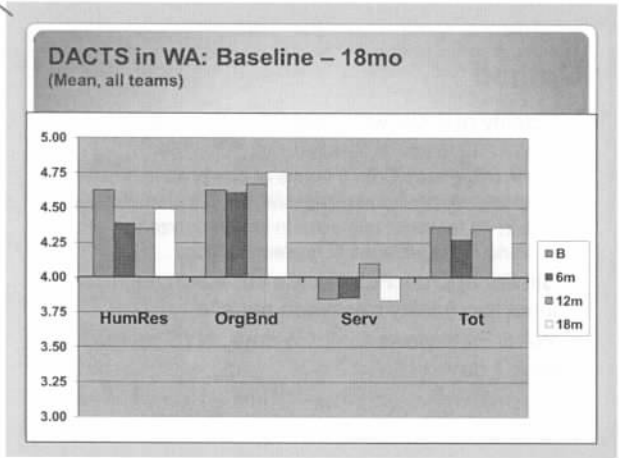
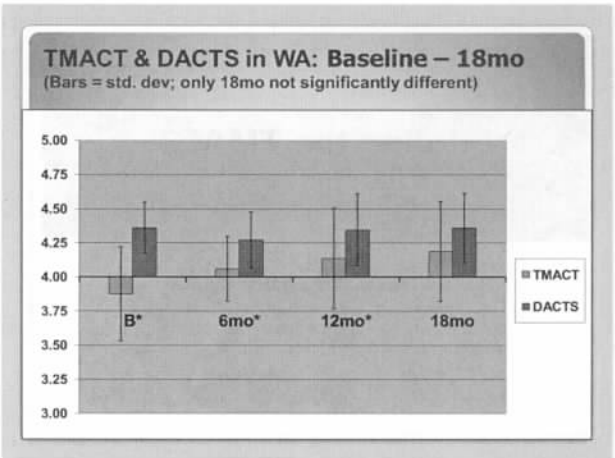
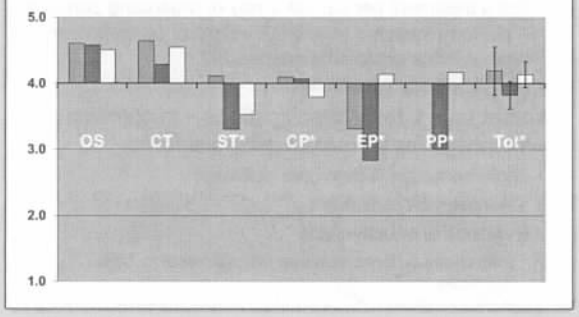




TMACT in Three States
(* = Significant variance among States)



Applying the TMACT for Quality Improvement

Our experience in several states

Themes Across States

- Recently piloted TMACT in WA, NE, FL, & PA
- Varied plans for using TMACT for QI purposes
  - State-driven QI vs. QI at local level
  - Some tied to outcomes
- Varied selection of trainees/fidelity reviewers
  - ACT team members and/or outside entities
- Generally consistent training model
  - 1-day orientation to the TMACT (some orientation to ACT model if needed)
  - 1½ days side-by-side training during fidelity review
  - Group consensus ratings & report peer-review
  - Repeated at least 1x per training cohort
- Varied approaches to training sustainability

State of Washington

- 10 teams statewide
- Primary goal: QI (with some tie to contracts)
  - Driven by the State
  - University provides training & TA to teams
- Trainees/fidelity reviewers:
  - Trained 7 reviewers statewide
  - Two reviewers per review: 1 State rep; 1 university rep
- Training model consistent w/ previous description
- University provides booster training of reviewers
- Plan to tie fidelity review data to outcomes – collected separately, analyzed by UNC

State of Nebraska

- Three teams statewide
- Primary goal: QI
  - Driven by the State
  - Plan to bring in consultants for ongoing training/TA
- Trainees/fidelity reviewers:
  - State ACT lead staff, MCO, local regions, Medicaid & team leaders
  - Future reviews will likely include team leaders
- Training model consistent w/ previous description (x3)
- Discussed ways to apply fidelity tools to collect some outcome data

State of Florida

- 31 teams statewide; 10-year history; tight funding
- Goal 1: QI via peer-review/consultation network
  - State: requested evaluation; facilitates; modest support
  - University provides initial training in fidelity evaluation
- Goal 2: Determine outcomes & relation to fidelity
  - Plan to link fidelity & outcomes: multiple databases, consumer survey; control group; University analyzes
- Trainees/fidelity reviewers statewide:
  - 5 trainee/trainer-reviewers; 8 more trainee-reviewers
  - Two reviewers per review: mostly team leaders
- Training model generally consistent w/ previous description, cascading to 2nd-generation trainees

Why Do We Bother?

- We still have something of a black box problem
  - Need to learn more about how ACT functions
- Recent research shows smaller effect sizes, e.g.,
  - UK studies – integrated community care, principally hospitalization outcomes
  - ICM – fewer specialists, higher caseloads
  - Specific EBPs (IDDT, SE)
- Possible sources of difference
  - Context: policies; community/culture; treatment system differences (including improvements in practices)
  - Selection: not all consumers should be recruited
  - Suboptimal implementation (poor fidelity)

Suboptimal Implementation?

- Background: ACT…
  - Not a treatment per se, but a way of organizing services
  - A platform intended to accrete whatever contemporary best-practice treatments are needed
  - Needs to keep up with field
- Inadequate fidelity specifications – in combination with incentives – weaken potential for…
  - Implementation & thus care delivered
    - Recovery for consumers
  - Evidence of effectiveness
    - Inferences & conclusions re: program design, best practices

Needed

- Adequate standardized measure of features theorized to be critical
- Participation across multiple settings / states
- Compatible measures of a range of outcomes
- Integrated analysis
  - Program processes, consumer characteristics, service system context, outcomes
  - Intent: identify empirically critical features and relationships to context & person variables
- Evidence to support and/or help reevaluate
  - Organizational, treatment, & boundary features
  - Person /program matching

Next Steps

Where do we go from here?

Next Steps

- Minor changes & call it done (for a while…)
- Continue current use & extend
  - WA (30-mo. reviews) & other states
  - Additional regions, states, countries
- Prepare/refine training materials & protocol
- Intended research (with additional support)
  - Fidelity measurement: reliability/validity; value added
  - Outcome research as described
- Enduring questions
  - ACT: benefit/cost; absorption of new technology
  - Fidelity: models; methods, intensity, timing

We Wish To Thank…

- Our initial funders at the Washington State Mental Health Division
- Washington State ACT Fidelity Reviewers:
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Tool for Measurement of Assertive Community Treatment (TMACT) PROTOCOL

Appendices

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Revision 3

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TMACT Appendices

Table of Contents

Appendix A. Sample Fidelity Orientation Letter

[DATE]

Dear XXX:

We look forward to meeting with you and your ACT team on [DATE]. Since a lot of information is collected during a fidelity assessment from multiple sources, we greatly appreciate you and your team's hard work to prepare the following data prior to our fidelity assessment. This advanced preparation allows us to reference these hard numbers and direct our interviews to include specific follow-up questions. Toward this end, we would like your assistance in completing the following attached documents prior to your next fidelity visit: **(1)** The Team Survey and **(2)** Client-level data in the Excel spreadsheet. Please note that the Excel spreadsheet includes worksheet tabs at the bottom for two different spreadsheets - the first outlines directions and definitions and the second is for the team to enter their client-level service data for all clients currently served. ** Please make sure to read the directions and definitions **before** completing the client-level data in the Excel spreadsheet. In particular, we ask that you create a unique client identifier for each person you serve and use that unique ID to fill out the client-level data in the Excel spreadsheet. Please make sure to have a copy of the actual client names and their corresponding unique client ID's available for each interview during the fidelity review, as team members will be asked to talk about their experience in working with several of the clients listed. We will also be asking for a copy to have on hand while we are visiting your team.

We find that it is most helpful for the team leader to work with various team members when completing the client-level service data (e.g., working with the co-occurring disorders specialist to fill out which clients are receiving integrated treatment for co-occurring disorders services). We would like to receive both sets of completed documents by **[DATE]**. As much as possible, it is important that we observe your ACT team conducting "business as usual" during the fidelity review. As a result, we will strive to avoid altering your daily activities in order to accommodate our visit. We will plan to build an agenda for the day tailored to your team, but generally, here are the components of the two-day review (with a few questions embedded in red font below to help us build our agenda):

- **Chart reviews** -- As part of the review, we will randomly select and examine approximately 20% of your client charts, or a minimum of 10 charts, for clients currently served within the ACT team (i.e., 20 charts on 100-client teams). We will need access to all parts of the chart, including assessments, and progress notes. Do you use an electronic medical record or will we be accessing hard copy charts? We would appreciate it if you could reserve a room that is spacious and private so that we may conduct our chart review, which requires some spreading out of materials, and hold our staff interviews as well.
- **Review of daily team meeting tools and documentation -** This documentation may include Weekly Client Schedules, Daily Staff Schedules, and any communication logs used by the team. We will ask for access to these documents throughout the review, depending on when they are not in active use by the team.
- **Team member interviews** - We will plan to interview the team leader for approximately 1 ½ hours in the morning of the first day and 30 minutes the afternoon of the second day. We will also interview the psychiatric care provider (45 minutes), nurse(s) (30 minutes), employment specialist (60 minutes), co-occurring disorders specialist (60 minutes), and peer specialist (45 minutes). If your team has a housing specialist, we would like to spend up to 30 minutes interviewing that person as well. If there are multiple people in each position, we would like to interview all of them at once, if possible. We would also like to interview the two most veteran clinicians not otherwise in a specialty role, with at least one in a therapist role. One may also be someone who assumes more of a role in providing psychiatric rehabilitation (90 minutes). Please note that if you have any team members who are in a secondary role within a certain specialty area (for example, you have one person designated as the employment specialist, but you have another team member who also provides a significant amount of

employment and educational services), please let us know so that we can also include them in our scheduling of various team members. Further, do you have any particular staff who only work one of the days we're there, and whom we need to make sure to schedule during that day?

- **Client interviews** - We would like to speak with a group of clients all at once if there happens to be a scheduled group during one of the days of our visit. If such a group is scheduled, we ask that the group leader set aside the last 20 minutes for us to speak with consenting clients during this time. Questions will be focused on the services they receive from the team. Do you have such a group scheduled during our two-day fidelity review, and if so, what time and on which day is it scheduled? If not, when would be a good time to schedule a group interview with 3-5 clients during our visit?
- **Observation of the daily team meeting** – At what time is yours currently held?
- **Observation of a treatment planning meeting** -- Do you currently have any scheduled during one of the days of the fidelity review? If not, would it be possible to schedule one that was supposed to be held close to that date?
- **Community/home visits with one to two team members while they work with clients** -- We would also like the opportunity to accompany one or two team members on a community/home visit with a client for 30 minutes to 1 hour. Once we build the agenda, I will fill in possible times for these visits and see if that fits with your staff schedules.

Lastly, if your team uses any of the following forms, please provide two copies of these materials when we are onsite for your team's fidelity review:

- **Admission**: Admission criteria and screening tools;
- **Assessments**: Any ongoing assessments used by team members (e.g., co-occurring disorders, employment, functional, health/nursing);
- **Plans**: Treatment plan template, crisis plan template;
- **Discharge**: Transition-readiness (i.e., graduation) assessment or a list of transition-readiness criteria;
- **Daily Team Meeting forms**: A recently completed daily team schedule, an example of a team member individual schedule, a de-identified (i.e., cross-out name[s]) copy of a client log or an individual client log page depending on how your team logs daily contacts, a de-identified copy of a weekly client schedule; and
- **Other**: Any health communication forms used to correspond with non-ACT providers.
- **Client ID reference key** listing client names for reference while on-site

During the afternoon of our second day, we will plan to hold a debrief meeting with you, your team, and any agency administrators you would like to include to share initial impressions from the fidelity review. While we will not yet have ratings available, this will at least provide the opportunity for us to share our initial feedback regarding the team's strengths and recommendations for future training and improvement. We will then follow-up after our visit with a feedback report, which we will review with you during a formal feedback session at a later date.

Please do not hesitate to contact us if you have any questions at all regarding these materials. Many thanks again for your assistance in preparing for this upcoming visit with you and your team.

Thanks again,
XXX

Appendix B: ACT TEAM SURVEY

Team Name:		
Team Leader:	Year of Team Start-Up:	Today's Date:

Please answer each question about your ACT team as best as you can.

1. Please complete Table 1 below regarding your current ACT team staffing. **[OS1, OS5, CT1, CT3, CT6, ST1, ST4, ST7; H1 on DACTS]**

Table 1. ACT Team Staffing

Staff Name	Position	Date of Hire	Number of hours the staff member works with the ACT team per week[1]	Highest Level of Education	Specialized training, clinical experience, and Board Certification[2]	Number of years of experience with adults with SMI including their work with the ACT team	Daily Team Meetings per week. Note typical days of attendance (MTWRF)

[1]Include the number of hours each team member actually works, not just whether they are available (and may be holding another role in the Agency at that time).

[2] Specialized training (e.g., licensure, training in co-occurring disorders) and # of years of clinical experience. Please note if Psychiatric Care Provider is Board Certified in Psychiatry, and/or if any physician extenders have specialized certification and training in psychiatry.

1(a) Are any of the staff above interns or Residents? ☐ **YES** ☐ **NO**

(b) If yes, please specify length of time for the rotation of each staff person who is an intern or Resident:

Name: _____ Length of time in rotation: _____

2. In the past 2 years, how many staff members have left the team? If your team has been in existence for a shorter period, please indicate the time frame that corresponds to the length of time your team has been operating (e.g., in the past 1 year) **[H5 on DACTS]**

_____ **# staff members** _____**Time frame (if not in the past 2 years)**

3. In the past year, how many vacant positions did you have on the team each month? Please specify which positions were vacant. **[H6 on DACTS]**

Table 2. ACT Staff Vacancies

Month	# of Vacancies	Positions Vacant
January		
February		
March		
April		
May		
June		
July		

Table 2. ACT Staff Vacancies		
Month	# of Vacancies	Positions Vacant
August		
September		
October		
November		
December		

4. In the past year, how many staff members have been on leave for more than one month? (Include any extended absences, e.g., sick leave or leave after the birth of a child.) **[H5 on DACTS]**
   _____ **# staff on extended leave for more than one month in the past year**

5. In the past month, about how many hours on average did the team leader spend providing direct services to clients and natural supports each week? Direct services include face-to-face services and assessments, phone contacts, and treatment planning meetings that include clients and/or natural supports. **[CT2]**
   _____ **# hours per week providing direct services to clients/families**

6. In the past month, how often did the team leader meet with each of the two staff to whom he/she consistently provides the most clinical supervision? Clinical supervision is defined as the provision of guidance, feedback, and training to team members to assure that quality services are provided to clients (e.g., following evidence-based practices, negotiating ethical quandaries) and maintaining and facilitating the supervisee's competence and capability to best serve clients in an effective manner. Examples include mentoring in the field, review of clinical cases, and providing feedback on tools such as assessments and treatment plans. Only count meetings that were scheduled (vs. impromptu), regardless of whether the meeting took place within a group setting (i.e., weekly clinical meeting) or individually, or in the office or in the field. [**CT2]**

   Please indicate the number of times over the past month the team leader provided clinical supervision to each of the two staff most consistently supervised:

   _____ **# times you provided scheduled supervision to clinician #1 over past month**

   Team member name:_____

   _____ **# times you provided scheduled supervision to clinician #2 over past month**

   Team member name:_____

7. Client caseload size: **[OS1, OS5, OS10]**
   (a) How many clients are currently enrolled on your team? _____
   (b) How many clients is your team equipped to serve at capacity (i.e., caseload cap)? _____
   (c) How many clients were enrolled one year ago? _____

8. Do you currently serve any clients who you think do NOT meet ACT admission criteria and/or are inappropriate for ACT? Please mark one. **[OS6]** ☐ **YES** ☐ **NO**

9. If you answered yes, how many clients do you estimate do NOT meet ACT admission criteria? **[OS6]** _____**# clients who do NOT meet ACT admission criteria**

10. Approximately how many of your current clients were "stepped-up" to ACT from a less intensive program or service within your agency (i.e., client was enrolled with another program and eventually referred to ACT to receive more intensive services than s/he was receiving)? Do not count clients who went from a less intensive program to the hospital, and then were referred to ACT from the hospital. **[OS7]** _____**# clients "stepped up" to ACT from a less intensive program or service** [Note to evaluator: calculate the inverse, representing # of clients who were not stepped up to ACT from a less intensive program or service for rating OS7].

11. In the past 6 months, what is the highest number of clients admitted to the ACT team per month? **[OS8]** _____
Highest number of clients admitted per month, in past 6 months

12. In the past year, how many clients were discharged for the following reasons? **[OS9, OS10]**
 _____# unable to locate client
 _____# incarcerated
 _____# discharged as a result of not receiving authorization from managed care organization
 _____# transferred to a more restrictive service setting (e.g., hospital, nursing home, residential treatment center)
 _____# refused services and/or requested discharge
 _____# moved out of service area <u>without</u> assistance from team
 _____# moved out of service area <u>with</u> assistance
 _____# transitioned to less intensive services/graduated (i.e., was discharged because of significant improvement)
 _____# deceased
 _____# other: (please specify)_____

13. Please list all groups provided by your team.

Group Name/Type	Group Facilitator(s)	Frequency/Duration	Average # of Participants

14. Please list the last 10 client <u>psychiatric</u> hospitalizations, noting both the admission and discharge dates. A single client may be listed more than once. Include a brief description of the team's involvement in the decision-making process, clearly indicating whether team was involved in the admission/discharge process (note that "involvement" in an admission is not limited to directly facilitating a voluntary or involuntary admission). Additional questions will be asked about the team's role in the admission and discharge during the interview. **[OS11; OS5 and OS6 on DACTS]**.

Last 10 Client Psychiatric Hospitalizations (note that there may be repeated clients).			
Unique Client Identifier	**Approx. Admission Date**	**Approx. Discharge Date**	**Was team involved in the decision-making process around this admission and/or discharge? (indicate yes/no for each and provide brief summary)**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Appendix B. Excel Spreadsheet

DIRECTIONS & DEFINITIONS:
BACKGROUND: Your responses will be used to guide follow-up questions during the interviews and will be cross-referenced with the progress notes, assessments, and treatment plans in client charts. The chart review will be used to help verify that the services recorded in this spreadsheet are actually provided with relative consistency. Credit will not be given for services that are reported in this spreadsheet, but not clearly reflected in other data sources, per Protocol guidelines noted in TMACT Part II. **TO BEGIN COMPLETING THIS SPREADSHEET:** Please assign a unique identifier to all clients served by your team. Please keep a list of those unique identifiers so that we can ask about the work you are doing with each client during the on-site fidelity review. In the next spreadsheet, list all clients you serve using that unique identifier - DO NOT LIST NAMES OR USE INITIALS. Please indicate whether or not the client meets stated criteria and/or is receiving the listed services. While it is important to be accurate, please do not spend too much time laboring over completion of this spreadsheet (e.g., going through each client's chart); most ACT teams know the clients they serve well enough to be able to complete this information relatively quickly and accurately. Also be sure to delegate various team members to complete sections that are most in line with the services they provide and/or are most familiar (e.g., substance abuse specialist completes list of clients who receive integrated substance abuse services, nurses complete list of clients who receive daily and depot medications).
• Many items prompt you to document and reflect on services directly provided by the ACT team. Therefore, it is important to determine the boundaries of your ACT team staff, which is defined here as a staff member who is employed with the team at least 16 hours a week and attends at least 2 daily team meetings per week. Psychiatric care providers, when the team has more than one, must be employed with the team for at least 8 hours per week to be considered as part of the team. For example, there may be an agency therapist who provides services to several clients and this provider has frequent contact with ACT team members, but does not regularly attend daily team meetings and rarely participates in treatment planning. This provider would NOT be considered part of the ACT team and clients receiving services from this provider should be noted as "non-ACT." For some items, clients may receive a particular service (e.g., vocational services) from both ACT team and non-ACT team staff. If this is the case, please note BOTH.
STAGES OF CHANGE READINESS (Column A): **Early stage of change readiness** includes clients who are actively using substances, regardless of whether they view their use as a problem or not. These individuals may have expressed some desire to reduce or quit, but have not enacted the change. **Late stage of change readiness** includes clients who are committed to reducing or quitting substance and are seeking treatment to help make this change. Individuals may have experienced several trials of abstinence or significant reductions in use (with lapses/relapses) or may have maintained abstinence for an extended period of time (e.g., more than 6 months). **NOTE:** As individuals may use several substances (e.g., alcohol, marijuana, cocaine), stage of change is often substance-specific. Report each client's stage based on what seems to be the most problematic substance, excluding nicotine and caffeine abuse, which is addressed elsewhere. Assessments and treatment plans will

DIRECTIONS & DEFINITIONS:
be reviewed and cross-referenced with this item on the spreadsheet. Please do not leave this section blank. If your team does not assess for stages of change readiness or if the team has not yet assessed a specific client, please indicate this in the appropriate space.
INTEGRATED SUBSTANCE ABUSE TREATMENT (Column B): These include services provided by the Co-Occurring Disorder Specialist as well as other team members well-versed in integrated, stage-wise treatment for co-occurring substance use disorders. Core services include: (1) systematic and integrated screening and assessment and interventions tailored to those in (2) strategies to assist those in early stages of change readiness (e.g., outreach, motivational interviewing) and (3) and strategies to assist those in later stages of change readiness (e.g., motivational interviewing, CBT, relapse-prevention). Integrated substance abuse treatment reported here should be reflected across other data sources (e.g., progress notes, treatments plans, client schedules). Where someone is in a pre-contemplation stage of change readiness, the use of outreach should be strategic and there are clear efforts by the team to pay attention to substance use for the sake of ongoing assessment. NOTE: To be considered a group participant, client attends group at least 1 time per month. To be considered an individual substance abuse service recipient (inclusive of deliberate outreach aiming to eventually address substance use while using motivational interviewing efforts), at least 20 minutes per week is spent with the person attending to and/or addressing substance use. Substance abuse services, including deliberate engagement efforts, reported here should be reflected across other data sources (e.g., progress notes, treatments plans, weekly client schedules).
PSYCHIATRIC SERVICES (Column C): Core psychiatric services include psychopharmacologic treatment and regular assessment of clients' symptoms & response to medications, including side effects, provided by the team's psychiatric care provider; and medication monitoring and supports provided by other ACT team members. If the team has more than one psychiatric care provider, please indicate who the client typically sees (Provider 1 as "Pr1" or Provider 2 "Pr2," etc.). If the client receives psychiatric services from Non-ACT provider, please indicate "Non-ACT." NOTE: If a team has a psychiatric care provider that does not meet the inclusion criteria noted in CP3 (e.g., employed with team less than 8 hours per week if the team has more than one psychiatric care provider), then that psychiatric care provider is not to be counted as a Team Provider -- clients receiving services exclusively from this provider may not count as receiving psychiatric services directly from the team).
EMPLOYMENT AND EDUCATIONAL SERVICES (Column E): These include all services provided by the employment specialist as well as other team members well-versed in supported employment and supported education services. Core services include: (1) engagement; (2) employment and educational assessment; (3) job development; (4) job placement (including going back to school, classes); & (5) job coaching & follow-along supports (including supports in academic/school settings). Supported education services also should be noted in this column. Employment and educational services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, weekly client schedules).
COMPETITIVE EMPLOYMENT (Column F): Any paid job that is accessible to **anyone** in the population (not just individuals with disabilities). **"Other"** employment positions include volunteer, transitional employment, work crew, sheltered employment. Please also make note of anyone enrolled in school.

DIRECTIONS & DEFINITIONS:
PSYCHIATRIC REHABILITATION SERVICES (Column J): These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration). Psychiatric rehabilitation should address functional deficits as well as the lack of necessary resources, all of which are identified through the assessment process. As such, deliberate and consistent skills training which typically includes staff demonstration, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings. Psychiatric rehabilitation services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, and weekly client schedules). NOTE: Assessment and services focused on education or employment should be reflected in the Vocational Services column. Delivery of Illness Management and Recovery (IMR) services should be reflected in the Wellness Management and Recovery column.
WELLNESS MANAGEMENT AND RECOVERY SERVICES (Column K): These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. Examples of such services include development of Wellness Recovery Action Plans (WRAP) and provision of the Illness (or Wellness) Management and Recovery (IMR) curriculum. Wellness management and recovery services reported here should be reflected across other data sources (e.g., progress notes, treatment plans). NOTE: When completing the column for the provision of wellness management services, please specify the type of manualized or formal approach the client is receiving (e.g., IMR group, individual WRAP).
EVIDENCE-BASED PSYCHOTHERAPY (Column M): These services include formal therapeutic approaches that are based on established theory and techniques. Therapies are selected and employed given the presenting problem (e.g., behavioral activation for depression; cognitive behavioral therapy for psychosis; dialectical behavioral therapy for emotion dysregulation). Psychotherapy sessions are tied to clients' goals and written into the client's treatment plan and Weekly Client Schedule. Sessions are planned, are a minimum of 20 minutes in length every other week, and are conducted by a trained therapist. Psychotherapy services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, weekly client schedules). NOTE: Report any clients who have received formal psychotherapy in the past year and specify what type of therapy was provided (e.g., CBT, interpersonal therapy). Do not count motivational interviewing in both this column and in the Integrated Substance Abuse Treatment column, unless the client is receiving MI to address both substance abuse and other areas of his/her life where they may be in an earlier stage of change readiness (e.g., in precontemplation about moving from unsafe housing). Both sets of interventions must be documented separately in the treatment plan.
HEALTH/LIFESTYLE INTERVENTIONS (Column N): These services include skills or strategies targeting positive changes in health and/or lifestyle (e.g., smoking cessation, weight management, diabetes management). Indicate the specific type of program or strategies and the health/lifestyle target (e.g., Learning About Healthy Living for smoking cessation, Integrated-Illness Management and Recovery [I-IMR] for health behaviors in general, InShape for weight management, individual weekly walk for cardiovascular health).

DIRECTIONS & DEFINITIONS:
CURRENT HOUSING (Column O): Clients live in many different residential settings. We are interested in knowing which clients are residing in an environment where a large proportion of fellow residents (whether referred to as "patients," "tenants," or "residents") also likely have a disability. Please simply indicate with a "Yes" if client lives in a residence where at least 25% of neighbors/roommates also likely have a disability and that housing is DESIGNATED for serving this particular population. Follow-up questions will further clarify whether this environment is an institution, substance abuse treatment facility, nursing home, group home, congregate housing (e.g., apartment complex or boarding home), family home, or other type of organization. **AFFORDABLE AND SAFE HOUSING (Columns P and Q):** We are interested in clients who are residing in housing that is affordable and safe. Most clients who receive ACT services rely on disability benefits alone and a large proportion of their money goes toward housing expenses; they are then left with few choices other than unsafe housing that is more affordable. Subsidized housing is one of the ways in which clients gain access to more affordable and safe housing. Indicate in Column O if a client is currently receiving a housing subsidy, or is at least on a waitlist to receive such a subsidy. For those who are not indicated as not currently receiving or waitlisted to receive a subsidy, indicate in Column P if they are paying less than 30% of their income on housing expenses (rent and utilities). NOTE: We do NOT expect teams to conduct precise calculations to determine whether a client meets criteria for Column P. Instead, we recommend that teams consider a client's approximate income, then calculate what 30% of that income amounts to, and judge whether housing expenses are less than that amount (resulting in an "X" for that client in Column P). Exclude clients who may be paying less than 30%, but are living in unsafe housing. For example, Mary is not receiving, nor waitlisted to receive, a housing subsidy (nothing marked in Column O). The team knows that Mary only receives disability benefits for $610 per month. Thirty percent of $610 is $183 (610 * 0.30); the team knows that Mary is definitely paying more than $200 per month in housing subsidies, resulting in no mark ("X") for Column P.
NATURAL SUPPORTS (Column X): Contacts with informal natural supports include face-to-face, telephone, or email. This includes people in the client's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy - if a family member is also a paid service provider, they are counted as a natural support). Contacts with primary care physicians, parole officers, residential staff, and employed payees should NOT be counted in this item. Do not answer yes or no for this item. Please provide a specific number of contacts (in past month) for each client listed.

Snapshot of ACT Client & Service Data (to be collected at the individual client level for each team) (Excel Spreadsheet P.1)						
		A	**B**	**C**	**D**	**E**
ACT Client (Use unique identifier, NOT name).	In the column below, note whether the client has been enrolled in ACT services for at least 90 days.	For each client with a **co-occurring disorder**, indicate whether they are in an 'early' or 'late' stage of change readiness. See definitions.	Does the client receive **integrated treatment for co-occurring disorders directly from the ACT team**? Indicate 'individual' (more than 20 mins per week), 'group' (more than 1 time per month), or 'both.' If client receives co-occurring disorders services from non-ACT providers, note as 'non-ACT.'	Does the client receive **psychiatric services** directly from the ACT psychiatric care provider? Indicate 'yes' for single team prescriber and 'Pr1' and 'Pr2,' etc. for multiple team psychiatric care providers. If client sees non-ACT provider, note as 'non-ACT.'	Does the client live in a **supervised residential setting** where **medication monitoring services** are received from non-ACT staff? Indicate 'yes' or 'no.'	Does the client receive **employment and educational services directly from the ACT team?** (see definition) If receives employment and educational services from non-ACT providers, note 'non-ACT.'
Relevant TMACT items		*ST2*	*ST1; ST2; EP1*	*CP7*	*CP7*	*ST4; ST5; EP2*
Client 1						
Client 2						
Client 3						

Snapshot of ACT Client & Service Data (Excel Spreadsheet p.2)							
	F	**G**	**H**	**I**	**J**	**K**	**L**
ACT Client (Use unique identifier, NOT name)	Is the client **currently employed and/or enrolled in school?** If employed, indicate whether it is competitive employment, school, or 'other.' (see definition).	For working clients, specify where they currently work.	For working clients, specify the **type of position** they currently hold.	For working clients, indicate whether they got the job themselves or the team assisted with getting the position. Indicate 'self' or 'team.'	Does the client receive **psychiatric rehabilitation services directly from the ACT team?** (PLEASE carefully read definition provided). If receives psychiatric rehabilitation services from non-ACT providers, note 'non-ACT.'	Does the client receive **formal and/or manualized wellness management and recovery services directly from the ACT team?** (See definition) If yes, please specify the type of WMR service used and whether it is group or individual.	Does the client attend clubhouse, day treatment, drop-in center services or a partial hospitalization program? (Specify which type)
Relevant TMACT items	*ST5; EP2*	*ST5; EP2*	*ST5; EP2*	*ST5;EP2*	*CP8; PP4*	*ST7; ST8; EP3*	*ST5; CP8; EP2*
Client 1							
Client 2							
Client 3							

ACT Client & Service Data (Excel Spreadsheet p.3)						
	M	**N**	**O**	**P**	**Q**	**R**
ACT Client (Use unique identifier, NOT name)	Has the client received **individual and/or group psychotherapy in the past year from ACT team?** (See definition) If yes, please specify the type of therapeutic strategies used. If sees a non-ACT provider for therapy, note 'non-ACT.'	Does the client receive **health/lifestyle intervention services directly from the ACT team** (See definition)? If yes, please specify the type of service provided and targeted condition or behavior.	Indicate whether the client's **current housing is in a residence where 25% or more of the other residents or tenants likely have a known disability** (See definition). If the client is currently unsheltered (street homeless) or emergency sheltered, please type in HOMELESS)	Indicate whether the client is currently receiving a **housing subsidy** ("subsidy") or is on a waitlist for a subsidy ("waitlist").	Of those clients who do not receive a housing subsidy, mark ('x') which clients **pay 30% of their income or less on safe housing**, including rent and utilities. (NOTE: Exclude individuals in affordable, but clearly unsafe, housing.)	Indicate whether **treatment participation is a condition of their housing/ residence** and further note if the requirement is that they receive any services (note **'any'**), or specifically ACT (note **'ACT'**).
Relevant TMACT items	*EP7*	*CT7*	*EP8*	*EP8*	*EP8*	*CP2; EP8; PP4*
Client 1						
Client 2						
Client 3						

ACT Client & Service Data (Excel Spreadsheet p.4)						
	S	**T**	**U**	**V**	**W**	**X**
ACT Client (Use unique identifier, NOT name)	Is the client on **involuntary outpatient commitment** or conditional release? If yes, please specify which one.	If the client has a **representative payee,** indicate if the payee is agency/team, natural support, or independent organization/individual. Also note whether money is disbursed weekly or more or less often (e.g., individual receives allowance weekly or two times per week). E.g., "Indep Org; Weekly."	Does this client have a legal **guardian**?	Please indicate how individuals are receiving oral psychiatric medications: (1) on own; (2) from natural supports; (3) from residential staff; (4) from ACT Team. If from ACT Team, please also indicate the **amount of oral medications the individual receives at a given time** (e.g., daily, 2X/wk, weekly, monthly)	Is this client on an **antipsychotic depot medication** (i.e., injection)? Please state the medication name.	Indicate the number of contacts the team had with clients' **natural supports** this past month (see definition). Please indicate the **number** of contacts (i.e., do NOT answer yes or no).
Relevant TMACT items	*CP2; PP4*	*CP2; PP4*	*CP2; PP4*	*CP2; PP4*	*PP4*	*CP5*
Client 1						
Client 2						

Appendix C. Sample Fidelity Review Agenda

ACT Team:_____ Date:_____

TMACT Fidelity Review
FINAL SCHEDULE

Day 1: [DATE]

8:00 – 8:30 AM	Fidelity reviewer check-in/review of agenda
8:30 – 10:00 AM	Interview with team leader (*note: team leader phone interview completed before onsite evaluation)
10:00– 10:45 AM	Interview with psychiatric care provider (one reviewer) Simultaneous interview with nurses (one reviewer)
10:45 – 1:00 PM	Chart reviews/working lunch
1:00 – 1:45 PM	Observe treatment planning meeting
2:00 – 3:00 PM	Interview with co-occurring disorders specialist
3:00 – 3:30 PM	Continue chart review
3:30 – 4:30 PM	Observe daily team meeting

Day 2 [DATE]

8:00 – 9:00 AM	Fidelity reviewer check-in/review of agenda/finish chart reviews
9:00 – 9:45 AM	Interview with peer specialist
9:45 – 11:00 AM	Interview with mental health clinicians
11:00 – 11:30 AM	Interviews with clients (during last 20 minutes of scheduled group)
11:30 – 12:30 AM	Observation of community visits with mental health clinician (one reviewer) Simultaneous interview with employment specialist (one reviewer)
12:30–1:00	Follow-up interview with team leader regarding assertive engagement (CP2) and any other remaining questions
1:00 – 2:00 PM	Working lunch on our own/prep for debrief
2:00 – 2:30 PM	Debrief with ACT team and agency

County East ACT Team
Fidelity Assessment
November 29th and 30th, 2017

On 11/29/17 and 11/30/17, Lorna Moser, Ph.D. of UNC Institute for Best Practices and Maria Monroe-DeVita, Ph.D. of University of Washington Seattle visited the County East ACT Team in [Some City] for assessing the team's adherence to the Assertive Community Treatment (ACT) model, a requirement of DHHS. This report documents the findings and recommendations of this fidelity evaluation.

The Tool for Measurement of Assertive Community Treatment (TMACT)

Evaluators assessed the County East ACT Team's fidelity to the ACT program using the Tool for Measurement of Assertive Community Treatment (TMACT).[1] The TMACT is an enhanced version of the Dartmouth Assertive Community Treatment Scale (DACTS).[2] The scale has been piloted in several states and countries. The TMACT and DACTS are very similar in structure and organization. Each item is rated on a 5-point behaviorally-anchored scale, ranging from 1 (not implemented) to 5 (fully implemented). The ratings are based on the *current* structure and activities of the team (i.e., not future plans).

The TMACT includes the following six subscales:

1. Operations & Structure (OS)
2. Core Team (CT)
3. Specialist Team (ST)
4. Core Practices (CP)
5. Evidence-Based Practices (EP)
6. Person-Centered Planning & Practices (PP)

Data Sources

During this fidelity evaluation, the reviewers examined a variety of data sources. We reviewed 14 charts of enrolled clients who had been served by the team for at least three months. Chart data were examined for a recent four-week service period from 10/22/17 – 11/18/17, in addition to the most recent assessments and treatment plans. The fidelity evaluation team also interviewed the following team members:

- Team Leader – Stella McCartney
- Psychiatric Care Providers – Dr. Wilson Owen and Marissa del Toro
- Co-Occurring Disorders Specialist – Josie Crane
- Nursing staff – Matt Tesla and Gail Simone
- Employment Specialist – John Parker
- Peer Specialists – N/A
- Clinicians – Lucy Strong and Dave Bowie
- Program Assistant – Odeleen Kay

We observed one daily team meeting and one treatment planning meeting and conducted a group interview with 4 clients. Considering information gathered from all data sources, we rated the County East ACT Team across all items of the TMACT, except for ST8, as TMACT protocol states this item cannot be scored if the Peer Specialist position has been posted, but unfilled for fewer than 6 months.

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[1] Monroe-DeVita, M., Moser, L. L., & Teague, G. B. (2011). The tool for measurement of assertive community treatment (TMACT). Unpublished measure.

[2] Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, *68*, 216-232.

Overall Fidelity Score

The total **TMACT fidelity rating** for **County East ACT Team** is **3.7.** A summary of all item scores can be found in Table 1 below. This total rating suggests that the team is implementing ACT at a moderately high level of quality and adherence, which is an improvement from the previous review where the team was rated as 3.2. Excellent job on making important improvements!

Table 1. Summary of TMACT Items and Ratings – County East ACT Team

ITEM		RATING	
OPERATIONS & STRUCTURE (OS) SUBSCALE			
		March 2016	**November 2017**
OS1	LOW RATIO OF CLIENTS TO STAFF	4	**5**
OS2	TEAM APPROACH	3	3
OS3	DAILY TEAM MEETING (FREQUENCY & ATTENDANCE)	4	**5**
OS4	DAILY TEAM MEETING (QUALITY)	3	3
OS5	PROGRAM SIZE	4	**5**
OS6	PRIORITY SERVICE POPULATION	3	**5**
OS7	ACTIVE RECRUITMENT	4	4
OS8	GRADUAL ADMISSION RATE	4	**5**
OS9	TRANSITION TO LESS INTENSIVE SERVICES	3	3
OS10	RETENTION RATE	3	**4**
OS11	INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS	3	**4**
OS12	DEDICATED OFFICE-BASED PROGRAM ASSISTANCE	2	**4**
	OS Subscale Average Rating	**40/12 = 3.33**	**50/12 = 4.17**
CORE TEAM (CT)			
CT1	TEAM LEADER ON TEAM	5	5
CT2	TEAM LEADER IS PRACTICING CLINICIAN	4	4
CT3	PSYCHIATRIC CARE PROVIDER ON TEAM	4	**5**
CT4	ROLE OF PSYCHIATRIC CARE PROVIDER IN TREATMENT	2	**3**
CT5	ROLE OF PSYCHIATRIC CARE PROVIDER WITHIN TEAM	2	**3**
CT6	NURSES ON TEAM	5	4
CT7	ROLE OF NURSES	3	**4**
	CT Subscale Average Rating	**25/7 = 3.57**	**28/7 = 4.00**

Table 1. Summary of TMACT Items and Ratings – County East ACT Team			
ITEM		**RATING**	
SPECIALIST TEAM (ST)			
ST1	CO-OCCURRING DISORDERS SPECIALIST ON TEAM	3	**5**
ST2	ROLE OF CO-OCCURRING DISORDERS SPECIALIST IN TREATMENT	N/A	**4**
ST3	ROLE OF CO-OCCURRING DISORDERS SPECIALIST WITHIN TEAM	N/A	**4**
ST4	EMPLOYMENT SPECIALIST ON TEAM	1	**2**
ST5	ROLE OF EMPLOYMENT SPECIALIST IN SERVICES	1	**2**
ST6	ROLE OF EMPLOYMENT SPECIALIST WITHIN TEAM	1	**3**
ST7	PEER SPECIALIST ON THE TEAM	4	1
ST8	ROLE OF PEER SPECIALIST	4	N/A
	ST Subscale Average Rating	**14/6 = 2.33**	**21/7 = 3.00**
CORE PRACTICES (CP)			
CP1	COMMUNITY-BASED SERVICES	4	**5**
CP2	ASSERTIVE ENGAGEMENT MECHANISMS	4	4
CP3	INTENSITY OF SERVICE	3	**4**
CP4	FREQUENCY OF CONTACT	2	**3**
CP5	FREQUENCY OF CONTACT WITH NATURAL SUPPORTS	3	2
CP6	RESPONSIBILITY FOR CRISIS SERVICES	4	4
CP7	FULL RESPONSIBILITY FOR PSYCHIATRIC SERVICES	4	**5**
CP8	FULL RESPONSIBILITY FOR PSYCHIATRIC REHABILITATION SERVICES	3	3
	CP Subscale Average Rating	**27/8 = 3.38**	**30/8 = 3.75**
EVIDENCE-BASED PRACTICES (EP)			
EP1	FULL RESPONSIBILITY FOR INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS	3	**5**
EP2	FULL RESPONSIBILITY FOR EMPLOYMENT & EDUCATIONAL SERVICES	2	**3**
EP3	FULL RESPONSIBILITY FOR WELLNESS MANAGEMENT AND RECOVERY SERVICES	5	3
EP4	INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS	3	**4**
EP5	SUPPORTED EMPLOYMENT & EDUCATION	3	3
EP6	ENGAGEMENT & PSYCHOEDUCATION WITH NATURAL SUPPORTS	3	3
EP7	EMPIRICALLY-SUPPORTED PSYCHOTHERAPY	3	**4**
EP8	SUPPORTIVE HOUSING MODEL	4	4
	EP Subscale Average Rating	**26/8 = 3.25**	**29/8 = 3.63**

Table 1. Summary of TMACT Items and Ratings – County East ACT Team			
ITEM		RATING	
PERSON-CENTERED PLANNING & PRACTICES (PP)			
PP1	STRENGTHS INFORM TREATMENT PLAN	3	4
PP2	PERSON-CENTERED PLANNING	2	3
PP3	INTERVENTIONS TARGET A BROAD RANGE OF LIFE DOMAINS	2	3
PP4	CLIENT SELF-DETERMINATION AND INDEPENDENCE	3	3
	PP Subscale Average Rating	**10/4 = 2.50**	**13/4 = 3.25**
	TMACT OVERALL RATING	**142/45 = 3.12**	**171/46 = 3.72**

This report provides a summary of strengths and recommendations, followed by individual item ratings and a brief rationale for each rating. As depicted in Table 1, relative areas of strength include Operations and Structure (4.17) and Core Team (4.00). Scales in need of most improvement include Specialist Team (3.00) and Person-Centered Planning & Practices (3.25).

Strengths

The County East ACT Team has shown significant growth since the review conducted nearly two years ago. Following some team member turn-over, most positions are now filled and overall, the compliment of the team includes a majority of veteran team members. The team was observed to have a formidable team dynamic, where trust and reliance amongst each other was evident. Josie, the co-occurring disorders (COD) specialist was hired shortly before the last review. Josie brings many strengths to this team, helping them further enhance their own understanding of integrated COD treatment, ultimately resulting in a greater penetration of this service. Overall, we found the team to be compassionate, patient and oriented towards clients' strengths. Under Stella's leadership and with greater involvement of Dr. Owen, the team has modified their efforts around screening and intakes, which has resulted in the team serving individuals who would appear to be more of a clinical priority for ACT services. Similarly, they have limited the number of new intakes per month, which likely had positive impacts across staff burnout and practices. During the previous review (March 2016), evaluators found that the team was serving a higher number of individuals with more non-specific mood disorders and personality disorders. Relatedly, the team has made some inroads in working with their local managed care entity to help ensure those most needing and benefiting from ACT are able to access this service. The team's advocacy efforts and commitment are appreciated and recognized by evaluators; at the time of the review, the team was serving two people *pro bono* as utilization management staff would not issue a re-authorization for services as they judged milestone success, such as employment or staying out the hospital, as significant indicators for discharge from ACT (as opposed to understanding the ACT team's role in helping clients gain and sustain successes, while continuing to manage and avoid risks to recovery).

Recommendations

The following recommendations are to help the County East ACT Team consider areas to further develop. The listed recommendations reflect a select number of areas that would likely result in the biggest changes in the team's operations, and therefore are not an exhaustive list. For the below recommendations to be successfully implemented and sustained, agency and team leadership, which should include Stella, Dr. Owen, Marissa, and other agency leadership, will need to assume a pro-active role in overseeing these changes, first educating staff about the importance of the change to gain

some “buy-in.” Change takes time; we encourage the County East ACT Team to use these recommendations to create a strategic plan over the course of one to two years. Some recommendations will be quicker to implement than others. A team that can advance from a 3.7 to at least a 4.0 on the next TMACT review would be showing good progress.

We focus our recommendations on the following major areas: 1) Individual Placement and Support (IPS) model of supported employment; 2) Revise the planning and staff scheduling process to better use team members to meet clients’ needs; 3) Hire a Peer Support Specialist and expand wellness management and recovery services; 4) Enhance and expand work with clients’ natural supports; and 5) Continue expanding work of integrated medical team.

Recommendation #1: Individual Placement and Support (IPS) model of supported employment. A critical area of development within the team is their understanding and practice of IPS. Many individuals are interested in, or at least ambivalent about, working or returning to school. Taking such a step may be key to their recovery. John is relatively still new to this team and role. He came with little specific training and experience in delivering employment services, let alone IPS. Despite his lack of training, he does have a positive attitude and values how employment can be key to someone’s recovery. In addition to his need for additional training and supervision to further his competency, he is underutilized in his role. We estimated that about 50% of his time is dedicated to employment related services, which includes engagement and outreach. More strategic scheduling of his time, as we speak to further in Recommendation # 2 below, will help John have opportunities to practice his skills and yield greater results by having more concentrated employment services. The team as a whole varied greatly in their understanding and practice of key elements of IPS. For example, departures included: some team members expecting greater symptom stability before assisting with employment goals (or even attempting to engage in discussion of employment as an option); variation in efforts to try to understand what someone is wanting for employment, which would be assisted if a Career Profile was completed and used; and strategic use of ongoing supports to help people keep employment. John’s efforts around job development are applauded; he would benefit from more focused training on how to approach employers with key follow-up steps to groom those relationships.

Although John has been exposed to the Career Profile and informally tries to gather information captured in this tool, we strongly recommend that he receive more training in how to work with clients to complete and use a Career Profile, as it is at the core of many IPS practices (e.g., person-centered job searches, planning and delivering thoughtful supports). Some individuals would benefit from and desire job coaching, but John expressed concern for his lack of ability to provide such services. Benefits counseling was also not provided. Many individuals hesitate returning to work for many reasons, which can include fear of losing their benefits and not understanding work incentive options, Being skillful in benefits counseling (in addition to having warm connections with local experts on the topic) is not only necessary to assisting someone once they have a job, but can be an important part of the initial engagement effort. Likewise, John and the team using motivational interviewing skills to help people consider employment and school, especially in light of other recovery goals, is strongly recommended. In addition to John devoting more concentrated time to employment services, we offer recommendations in Recommendation #2 about designing individualized treatment teams given client needs and goals. These individualized teams assume a more active role in ongoing assessment, planning, and service delivery. Lastly, as this team recruits and hires a Peer Support Specialist (see Recommendation #3), consider the ways in which the peer specialist can play an intentional supportive role to delivering employment services.

The **best resource** to refer to is www.ipsworks.org. On this site, there are online trainings in which John and other team members (particularly Stella, the team leader) can participate. As County teams have other employment specialists, we also strongly encourage opportunities to routinely gather for group supervision, peer mentorship, and sharing of resources. Other resources that may be helpful include:

- The free Supported Employment Toolkit on the SAMHSA website: http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365
- The book: Supported Employment: A Practical Guide for Practitioners and Supervisors, Second Edition by Swanson, Becker, Drake and Merrens (2008).
- The manual: Supported Employment: Applying the Client Placement and Support (IPS) Model to Help Clients Compete in the workforce by Swanson and Becker (2011)
- Institute for Best Practices website: www.institutebestpractices.org

Recommendation #2. Revise the planning and staff scheduling process to better use team members to meet client's needs. Given that ACT is a "one-stop treatment shop" serving people who we presume to have complex and wide-ranging needs, the establishment and careful use of more personalized individual treatment teams (ITTs) is recommended. ITTs carry out specific directions laid out in the person-centered plan (PCP), which in turn should result in both a Team Approach, but also a broader range of services being delivered to a given client (see PP3, OS2, and all Full Responsibility items: CP8, EP1, EP2, and EP3). The team has been working to revamp their planning process as of five months ago and have been attempting to create and use ITTs. The ITTs have been composed of a primary worker, a secondary staff, and one nurse. The team is headed in a good direction in this regard, but we suggest the team consider less rigid team member assignments to be accommodating to client needs.

Relatedly, as the team continues to build on their own repertoire of what they have to offer (skill enhancement) and further builds in more routine assessment practices, the actual planning and consequential delivery of a range of individualized services happens with greater ease. This entails a last step of "walking over" planned interventions into staff and client schedules and then using the daily team meeting to help hold people accountable to those schedules as much as possible (given the nature of ACT, emerging needs, and proactive contacts coming up).

Scheduling Interventions by way of the ITT and daily team meeting. In review of plans, listed interventions varied in the extent they were individualized, personal, and specific, which can limit the ultimate instructions carried out through the daily team meeting, With expansion of the team's skills and treatment focus (via assessment), we believe this will only get stronger. The next step is for planned and specifically stated interventions to "walk into" a client schedule that then drives the day-to-day scheduling. Documented interventions not only specify the "what," but also the "when" and the "who." This level of planning, when put into practice, will also be taking into consideration the logistics of staff availability and efforts to maximize on direct time and limit indirect time (travel). Scheduling should reflect several tools that intersect: client schedules, staff schedules, and daily team schedules, which are basically pre-populated with planned interventions and contacts, but modified given assessment data shared during the meeting.

In planning the client's schedule, we recommend that the team consider the overall level of support and oversight a client may benefit from. This level of support and oversight may consider safety risks (i.e., benefitting from more frequent staff check-ins to monitor status), cognitive challenges, including disorganization (i.e., benefitting from more frequent contacts as staff visits help organize and anchor the client), and complexity of needs (i.e., what is needed cannot be effectively delivered in two visits in a week).

What follows is making a list of the client's needs (interventions, which may include supportive check-ins and medication deliveries for those with a high number of planned contacts), priority staff to deliver (ITT), and transplanting these visits onto staff schedules. As geography and location will likely assume some role in scheduling, also consider how to maximize staff time by weighing in geography (ideally, last, after attempting to schedule per the ideal arrangement). When clients need a high frequency of visits, we encourage that ITT staff take the lead. Other staff may fill in to help with the higher demand of

visits during a week, but try to minimize the rotation of all staff. Ultimately, what results should be both client schedules and staff schedules that cross-walk with each other, and where daily team schedules are essentially prepopulated with planned interventions and contacts. This process lends to easier checks on how ITTs are not only formed but used in service delivery.

The daily team meeting is a place where the planned schedule may be revised and flexed, as needed, to accommodate for emerging needs, proactive contacts, and staff time away. Also, it can be the place to capture (in a snapshot) what is being provided and relevant reactions for a given client in a given month. This, too, provides a way to review the range of services, level of care, and use of a team approach for a given client and, in turn, further helps the team "right course" its service delivery.

When developing interventions, pay close attention to functional skill deficits that would benefit from more ongoing teaching, coaching, role-playing, and rehearsal, as well as ways to involve, intervene with, and/or help develop natural supports. Many individuals would also benefit from more deliberately delivered therapy to address a behavior challenge and/or distorted thinking. Stella and Lucy are doing a good job of assuming this role within the team, but penetration would increase with better assessment and planning around which clients would best benefit from therapy.

Person-Centered Planning. In the actual development of a person-centered plan, we encourage the team to host two meetings. In the first meeting, ITT staff come together to share, review, and consider targets for intervention that will help a client move towards their larger life goals. Use the assessment data the team has collected along the way, with Stella remaining "in-the-know" regarding assessment data across all clients served by the team. The goal of this meeting is to synthesize and interpret assessment data and essentially come up with a draft plan. The next step is to then host a formal planning meeting that includes the client. In this meeting, the drafted plan is presented and then likely revised/enhanced. We recommend only including those who are part of the ITT, team leadership (including psychiatry, when available), client, and natural supports. More intimate groups (rather than the whole team or nearly the whole team) tend to be more productive and for some people, less intimidating.

In the meeting that involves the client, we recommend it begins with an emphasis on the person's strengths and elicits thoughts from the client. Then, invite others to offer their observations. Consider writing this up on a board so that the individual has it to reflect on throughout the meeting (use visuals/pictures if the person is illiterate). When proceeding to clarify recovery goals, spend time trying to understand what matters most to the individual and defining what that is with the person. It is not uncommon for teams to unintentionally move too quickly past what one expresses as a personal value or goal, inserting our own ideas for what should be in the plan (e.g., overlooking the importance of reconnecting with family, instead focusing a great deal on healthy living behaviors and medications). We observed this to be the case in the meeting we sat in on; the team directed conversation back to diabetes management, not working with the client to help him consider and give responses beyond "I don't know."

We **append several handouts** for reference. We include two client schedules and a related daily team schedule. The daily team meeting handout is an example of how it may be set up; larger teams can do the same but use legal paper to capture all staff columns. We also attach two example client logs for two clients. We understand that the team is accustomed to using electronic medical records and Excel to assist with daily meeting tools. We share these handouts to help show how these tools should be intersecting with one another. We also refer the team to the following resources:

- Neal Adams and Diane Grieder site, which includes information on their 2nd Ed. Book: http://www.personcenteredtreatmentplanning.com
- Diane Grieder, Janis Tondora, and Valerie Way's workbook on PCP development https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/

- Refer to this Presentation delivered by Janis Tondora: http://www.ct.gov/dmhas/lib/dmhas/publications/CSP-PCPdocumentationTraining.pdf
- UNC Institute for Best Practices: www.institutebestpreactices.org

Recommendation #3. Hire a Peer Support Specialist and expand wellness management and recovery services. Although this position has been vacant for about one month at the time of the review, the vacancy was experienced during the review in both the type of services delivered and the culture within the team. We applaud the team's efforts to continue supporting individuals in developing and using Wellness Recovery Action (WRAPs). We understand that agency leadership has entertained the idea of not filling this position with a full-time peer specialist, which we believe would be to the detriment of this team's practices. The perspective of the peer specialist is valuable for the culture and practice of the team. Not to say that current team members don't come with their own lived experience (as many of us do!), a Peer Support Specialist is a central voice that helps anchor the team in the perspective of what it is like to experience what many of the clients served experience: involuntary commitment, feeling alienated, homeless, helpless and hopeless. Peers are an asset to the clients, providing emotional support, further normalizing clients' experiences, teaching advocacy skills, and serving as a beacon of hope for clients' recovery. One area of expertise we encourage the peer support specialist to have is in wellness management and recovery (WMR) activities, which can also be delivered by anyone on the team. Empirically supported WMR programs, which address a broader range of wellness areas that promote more independence, include topics related to psychoeducation about mental illness and the stress-vulnerability model, building social support, recognizing signs of decompensation and heading off crises, coaching to help clarify treatment preferences, coping with stress, symptom management, and getting needs met within the mental health system and community. Assisting individuals in creating WRAPs and/or following WMR curriculum are ideally formally delivered to interested participants both individually and via groups. Resources that may be helpful to further educate the team on wellness management approaches include:

- The IMR Toolkit on the Substance Abuse and Mental Health Services Administration (SAMHSA) website: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/
- The manual: IMR: Personalized Skills and Strategies for Those with Mental Illness (3rd edition) by Gingerich and Mueser (2011).
- The book, Wellness Recovery Action Plan by Copeland (2000).
- Whole Health Action Management (WHAM): http://www.integration.samhsa.gov/health-wellness/wham
- The website: The National Resource Center on Psychiatric Advance Directives at http://www.nrc-pad.org/
- Temple University Collaborative on Community Inclusion: http://tucollaborative.org/

Recommendation #4. Enhance and expand work with clients' natural supports. The team reported having contact with the natural supports of 35% of their client caseload. Work in this area seemed inconsistent for those who were receiving some contact by the team. ACT teams are positioned to help clients work toward their goals by deliberately including natural supports as part of the broader treatment team while also proactively looking for opportunities to educate and influence the natural supports in a manner that ultimately is best for the client. Teams often struggle with prioritizing engagement and treatment efforts that target the natural supports of clients. It is within the responsibility of the team to assist clients in developing a network of natural supports, which may be inclusive of only non-family members (e.g., friends, romantic partners, church members, neighbors, friendly and supportive employers) where the client has long-severed ties with family or vice versa. The team can also work with the client to rebuild family relationships. When natural supports do indeed exist, there are several interventions that the team can and should be providing (all with client consent, which should be persistently sought even if client initially declines). First, the team plays a role in educating natural supports about their loved one's illness and effective treatments for that illness. Doing so both educates the natural supports as well as primes them to be attentive to signs of

decompensation and progress. Second, the team provides more proactive interventions to address behaviors that may serve to exacerbate client's symptoms and works with family and loved ones to develop healthy problem-solving skills. The team is a key source of support for helping natural supports truly understand the potential for clients and emphasizing the importance of a recovery-perspective. Finally, the team maintains a list of written local resources that may be of help to family members/natural support, routinely providing these resources to family members/natural supports.

Below are resources that can help develop family psychoeducation and supports:

- The Family Psychoeducation Toolkit on the Substance Abuse and Mental Health Services Administration (SAMHSA) website: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/familypsychoeducation
- Multifamily Groups in the Treatment of Severe Psychiatric Disorders by McFarlane, WR (2002).
- Family Psychoeducation for Serious Mental Illness by Lefley, HP (2009).
- The Complete Family Guide to Schizophrenia by Mueser, KT and Gingerich, S (2006)
- Family-to-Family Education Program offered by National Alliance on Mental Illness (NAMI)

Recommendation #5. Continue expanding work of integrated medical team. Following recommendations from the last review, we want to continue to stress the importance of the role of the medical team within ACT. By way of who is eligible and would benefit most from ACT, teams are serving individuals with complicated and severe psychiatric symptoms and often present with serious and multiple health concerns (which can be secondary to lifestyle [smoking, diet, poverty], treatment [medication side effects], and interactions with the healthcare system [not seeking out services, not receiving adequate care]). We are encouraged by the increase in psychiatric care provider time, with Dr. Owen at 0.40 FTE and Marissa at 0.20 FTE. Nursing time is temporarily down as the team has yet to staff up given the increased caseload. This no doubt puts more strain on Matt, RN and Gail, LPN.

Dr. Owen works closely with Stella in a co-leadership role and embraces his role as an educator to the team. We want to encourage the team to consider the trade-offs of having a full day in which Dr. Owen and Marissa are with the team (which allows for collaboration and coordination between the two) compared with more coverage, where the team has more in-person access to a psychiatric care provider across the week. As of now, the team does not have a psychiatric care provider present Thursday through Monday. Also, we encourage Stella to work with the nurses to streamline and integrate scheduling for both providers' time in a manner that ensures clients are receiving the appropriate level of follow-up support from Dr. Owen and Marissa. At the time of the review, both were independently managing their own schedules. Relatedly, we encourage the team to consider a broader array of planned interventions both Dr. Owen and Marissa could be assisting with, which could include delivering planned, brief therapies to a subset of clients as well as working in closer collaboration with nursing staff in delivering integrated healthcare. Nursing staff are not completing ongoing health assessments and client needs in terms of health concerns are variably being addressed. Clients would benefit from the medical team assessing and tracking such needs and making such interventions a higher priority in their work. We appreciate the concerns of Dr. Owen and Marissa to not be a default primary care provider, however, many clients struggle to get adequate care through traditional healthcare. There are many key ways the ACT team can be screening, assessing, and reasonably (safely) meeting these needs while continuing to link and coordinate with other providers. Nursing staff had many examples of their work around diabetes management. We encourage them to expand their health promotion and prevention in both individual and group formats. For example, nursing staff could cover topics in decreasing sedentary behaviors, improving diet and nutrition, safe sex practices, and smoking cessation.

TMACT Items Organized by Subscale. For each item, the criteria considered for a high-fidelity ACT team are noted. For many items, options for Full or Partial credit are available and indicated with an F (full credit), P (partial credit), or N (no credit) in the absence of supporting data for that practice. In the Comments section, evaluators may note observations unique to the team that influenced the ratings.		
Item	**Rating**	**Comments**
OS1. Low Ratio of Clients to Staff. Definition: The team maintains a low client-to-staff ratio, not to exceed 10:1, which includes all direct service staff except psychiatric care provider. The staff count also does NOT include other administrative staff such as the program assistant or other managers assigned to provide administrative oversight to the team.	**5**	The team is comprised of 8.0 FTE direct service staff (excluding psychiatric care providers, interns, and program assistant) serving 71 clients, resulting in a staff to client ratio of 1.0: 8.9.
OS2. Team Approach. Definition: ACT staff work as a transdisciplinary team rather than as individual team members; ACT staff know and work with all clients rather than carry individual caseloads. Although the entire team shares responsibility for each client, each team member contributes expertise as appropriate (i.e., by way of a person-centered plan, forming and using individual treatment teams [ITTs]).	**3**	Of the 14 charts randomly selected for review where there was at least one face-to-face contact, 10 client charts (71%) in this sample had face-to-face contact with at least three ACT staff in the four-week review period. The percent of clients seeing five or more staff in the four-week period was 44%, which may not reflect best practice and can further fragment services and negatively impact relationship building.
OS3. Daily Team Meeting (Frequency & Attendance) Definition: The team meets daily to review and plan services. To this end, most team members should be present to effectively carry out such a review. To constitute a daily team meeting, it must meet the following criteria: there is a review of clients' statuses; there is planning for future services; most team members are present.	**5**	The team holds a daily team meeting to review recent client contacts and plan the daily schedule at 11:00 AM Monday through Friday. Staff are expected to attend and participate, which was observed to be the case. The team had a protocol where absent staff passed on reports via secure email and another team member reported on their behalf. The team's psychiatric care providers each attended one day per week for the full meeting, which is an improvement from the last review where they only attended briefly for updates.
OS4. Daily Team Meeting (Quality). Definition: A high-fidelity ACT Team uses the Daily Team Meeting to fully serve the following functions:	**3**	We observed a Tuesday Daily Team Meeting. The team commences their meeting with Stella reviewing and updating "dashboard" information, such as who is in jail, hospital, upcoming IM injections, and pending admissions and discharges. She also inquired about crisis calls, of which none were reported. The team continued with roll call, where two team members (in this case, Dave and John) managed the client log books, each taking turns calling out client names (and then entering information into the log). Information the team shared tended to be clinically
Function #1: Conduct a brief, but clinically-relevant review of all client contacts in the past 24 hours;	P	

Function #2: Record status of all clients;	P	relevant and brief enough to keep the pace of the meeting going (we observed a couple of reports that would have benefited from "parking" and discussing more at length at the end of the meeting). Further, information shared was mostly focused on the last 24 hours except for the team re-sharing updates with Dr. Owen, who had not been with the team the previous three business days. In review of the client logs, they were organized nicely by person and by month and included space to note who (team member) and the nature of visit/summary. However, instead of being pre-dated, team members entering information made a new entry if there was information to enter; this format missed out on being able to visually capture days the client was not seen, which included attempts. Also, the quality of content documented varied considerably across who made the entries (some would just note, "doing ok," as an example). Client schedules existed but were somewhat vague; key team members working with the individual were listed as well as days of the week the client was scheduled to be seen. What was significantly lacking was specifying interventions to be carried out. A draft daily team schedules (M – F) are created the previous week (Friday), and then updated each day of the meeting. After the meeting, final mark-ups were quickly integrated into a master schedule and reprinted, handed out to all team members. Stella did appear on top of ensuring that emerging needs were on the schedule and being addressed. The team uses a central schedule where they input dentist, doctor/PCP, court, etc. appointments and Odeleen and Stella work to be sure this is integrated into the daily team schedule. We also observed one instance where the team shared an update on a client whose paranoia appears to be increasing. Dr. Owen led the brainstorming on next steps, which included reaching out to the client's aunt to enlist in more assertive outreach efforts to address problems appearing to be associated with the client not consistently taking medications (Criterion #5). Finally, although Stella handed out the previous day's schedule for reference during the roll call and appeared to be checking off that visits occurred, there was no mechanism in place to ensure that staff were held accountable to carrying out planned interventions.
Function #3: Daily Staff Schedule is based on person-centered plan-informed Client Schedules;	P	
Function #4: Daily staff schedule is based on clients' emerging needs;	F	
Function #5: Daily Staff Schedule is based on need for proactive contacts to prevent future crises;	F	
Function #6: Staff are held accountable for follow-through	P	
OS5. Program Size. Definition: Team is of sufficient absolute size to consistently provide 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.	**5**	The team is staffed with 8.6 clinical FTE staff, with a current caseload cap of 75 clients.

OS6. Priority Service Population. Definition: A high-fidelity ACT team serves a specific, high-service need population of adults with serious mental illness and are able to make decisions about who is served by the team.	**5**	Diagnostic information was reviewed for all clients served. This information suggested that approximately all clients (97%) may represent a clinical population who typically needs and/or benefits from ACT. The team reported that two clients may not be appropriate for the team; both are presenting with significant substance use challenges and the documented primary psychiatric diagnoses are currently being evaluated. Stella, team leader, and Dr. Owen each assume a proactive role in reviewing referrals and conducting initial intake assessments. The team indicated that they feel empowered to refuse inappropriate referrals and make decisions about who is to be discharged with minimal external pressure. A cited concern is some pressure to discharge clients before the team believes they are ready. The team has been exhausting all appeal processes in such cases, including deciding to serve two such individuals *pro bono.* See OS9 for further description.
Criterion #1: Team has specific admission criteria, inclusive of schizophrenia & other psychotic disorders or bipolar I disorder, significant functional impairments, and continuous high service needs, and exclusive of a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury or personality disorders.	F	
Criterion #2: Team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.	F	
OS7. Active Recruitment. Definition: There is often more individuals of need of ACT services than there are ACT services. Team makes an effort to seek out those most in need of this level of care.	**4**	The team is not currently at capacity, reported to be 75, with 5% open slots (Criterion #3). Of those clients currently served by the team, approximately 85% of clients appeared not to be "stepped up" from a less intensive agency program (Criterion #2). The agency operates targeted case management and outpatient therapy programs who have referred clients to ACT in the past. Most referrals are coming from their local hospital, other behavioral health providers who do not offer ACT, and their managed care organization (MCO). Stella reported that the team is familiar with staff at the local shelter, crisis center and jail, but have not conducted strategic outreach efforts to help these potential referral sources understand ACT and to help foster appropriate referrals. Stella does participate in a community stakeholder board that meets quarterly, which does involve various representation across community groups, and cited two examples where that participation resulted in referrals to the team.
Criterion #1: A high-fidelity team (or its organizational representative) actively recruits new clients who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team. The team regularly visits specific referral sources for outreach (e.g., community inpatient units, jail, shelters, system-wide community meetings where various referral sources meet regularly). Team conducts regular screening and planning for new admissions. Non-ACT staff (e.g., local government entity, or agency administration) may perform these outreach functions on behalf of the team; however, team must still actively build and maintain relationships with common referral sources. If team is at capacity, there is a mechanism for prioritizing admissions to the team (e.g.,	P	

waiting list) to ensure that new clients can be admitted to the team once there is an open slot. Also, if at full capacity, there may be less of a need to be doing active community outreach, but there is clear evidence that the team has developed and actively maintains positive relationships with referral sites.		
Criterion #2: Team is comprised of clients from common referral sources and sites outside of the usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach) or more restrictive agency programs. For Full Credit, at least 75% of clients from outside agencies/referral sources or from within more restrictive programs administered by parent agency (e.g., mobile crisis team) vs. less restrictive programs administered by parent agency (e.g., adult case management program). Partial Credit if 50% - 74%.	F	
Criterion #3: A high-fidelity team works to fill open slots when they are not at full capacity and/or the staff-to-client ratio is well below 1:10 on more mature teams. Full Credit if no more than 5% of slots are open. Partial credit for teams with 6% - 10% of slots open. Teams that are at least 2 years old with a client-to-staff ratio less than 6:1 (see OS1) does not qualify for full credit as the assumption is that there should be more slots available (i.e., capacity should be increased).	F	
OS8. Gradual Admission Rate. Definition: Program takes clients in at a low rate to maintain a stable service environment.	**5**	The highest number of clients admitted in a given month in the past six months is four. The team typically tries to not enroll more than two individuals per month to avoid overextending the team's resources, and/or diverting resources away from other clients. Stella reported that the unusual month of admitting four individuals was in response to an MCO request and that agency middle management stepped in to help the team for two months. Great job!
OS9. Transition to Less Intensive Services. Definition: The team has a reliable process for transitioning clients from the team who have demonstrated and maintained improvement and not requiring this level of care.	**3**	The team reported that six clients transitioned from the team in the past year, four of which appeared to be spurred by the MCO. The team did not agree with the MCO that these individuals were ready to graduate from ACT. The team uses a semi-structured transition readiness assessment tool to determine where individuals are at across various functional and

Criterion #1: Team conducts regular assessment of need for ACT services;	F	engagement domains. These assessments are typically completed every six months at the time of planning. In speaking with various team members, there were inconsistencies in the team members' understandings of what constitutes readiness to graduate (some cited "medication adherence" and "staying out of the hospital and jail" without accompanying growth-oriented outcomes). Individuals whose graduation were spurred by the MCO tended to be individuals who had stayed out of the hospital the past two years and were in part-time employment. The team asserts that its ongoing efforts have helped the clients maintain these successes and retracting ACT risks setbacks with these gains, per these individuals' histories. Examples were provided for the team's transition plans for two people currently in a transition phase; plans included titrating down contacts, clients taking public transportation to the office for scheduled meetings; and introduction to a new provider. Overall, the transition plan spanned a year. Team members were inconsistent in their reporting of whether and who would be followed post-transition, with Stella reporting that policy indicates all graduated individuals receive one phone call one month after discharge. We suggest modifying this policy to individualize who benefits from follow-up contacts and what this may look like for those individuals (e.g., some may benefit from more check-ins over a longer period, which can include a Memorandum of Agreement with the current provider). There is no waitlist and examples were offered where the team is able to immediately serve those who re-enroll, prior to getting initial authorization.
Criterion #2: Team uses explicit criteria or markers for need to transfer to less intensive service option;	P	
Criterion #3: Transition is gradual & individualized, with assured continuity of care;	F	
Criterion #4: Status is monitored following transition, per individual need;	P	
Criterion #5: Team expedites re-admission to the team if necessary.	F	
OS10. Retention Rate. Definition: Team retains a high percentage of clients given that they enroll clients appropriate for ACT, utilize appropriate engagement techniques, and deliver individualized services. Referral to a more restrictive setting/program would normally be considered an adverse outcome.	**4**	Considering the data provided on clients who were discharged for reasons other than death and transitions/graduations, we rated this item based on seven "drop-outs," per the protocol's definition (90% retention rate considering the average of current (71) and past year's (75) caseload sizes). Of note, the team originally reported that one individual went to jail, two went to more restrictive settings (nursing homes), and one refused services and was discharged. In addition to those four, we judged that three others that were originally reported to be "transitions/graduations" are a result of an MCO denial for service as the team clearly did not agree with the MCO's decision (we exclude from this drop-out calculation one person as the team sought to appeal the decision, per TMACT protocol).
OS11. Involvement in Psychiatric Hospitalization Decisions Definition: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary	**4**	The team was credited for being appropriately involved in the decision-making surrounding seven of the last 10 hospital events, which includes decisions resulting in admissions and discharges. The team reported that they are often able to assume an active role around admission decisions, with examples such as consulting with family members in decisions to hospitalize the client, consulting with admission staff at the hospital, sharing current records and offering clinical opinions, attempting to divert one admission as the ACT team assessed and believed the person could "ride out" their acute crisis at home with team's increased support

and involuntary admissions), contact with the client during his/her hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning).		(this person presents to the ER fairly often). The team struggles more in being consistently involved in discharge planning, reportedly due to hospital staff not welcoming ACT's role in assessment of disposition and planning for aftercare.
OS12. Dedicated Office-Based Program Assistance Definition: The team has 1.0 FTE of office-based program assistance available to facilitate the day's operations in a supportive manner to both team and clients. Primary functions include: (1) providing direct support to staff, including monitoring & coordinating daily team schedules and supporting staff both in the office and field; (2) serving as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports; and (3) actively participating in the daily team meeting.	**4**	Office-based program assistance is provided by Odeleen, who has been the team's program assistant for the past six years. Odeleen is full-time and is solely appointed to support the team at this time, which is a significant improvement from the last review where Odeleen was tasked with providing administrative supports to multiple agency programs. Stella and Odeleen described her responsibilities: she helps track key due dates, maintains the charts, assists with authorizations and billing, helps with document sharing across provider groups, and ensures that Release of Information and Disclosures are up to date and signed. She is situated in the office where walk-ins encounter Odeleen first and she can either meet their need or connect with a team member. Odeleen also receives all ACT phone calls. In terms of providing direct support to staff, particularly when in the field, information varied. Examples included team members reaching out to Odeleen for information such as addresses and phone numbers. The team also relied on texting each other and some examples reflected problematic consequences of not keeping communication more centralized with Odeleen involved. She does assume an active role in the daily team meeting, she tracks key performance and outcomes (e.g., notes hospitalizations, incarcerations, employment, housing episodes), and we observed her report out on her own client contact, which other sources indicated as typical.
Team has 1.0 FTE;	F	
Function #1: Provides direct support to staff, including monitoring & coordinating daily team schedules and supporting staff both in office and field;	P	
Function #2: Serves as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports;	F	
Function #3: Actively participates in the daily team meeting.	F	
CT1. Team Leader on Team. Definition: The team has 1.0 FTE (i.e., works 40 hours a week) team leader with full clinical, administrative, and supervisory responsibility to the team. The team leader has no responsibility to any other programs during the 40-hour workweek. The team leader must have at least a master's degree in social work, psychology, psychiatric rehabilitation, or a clinical related field, and a license in their respective field, and at least three years of experience. The team leader cannot	**5**	Stella is the team leader. She is full-time and meets minimal qualifications; Stella is a licensed clinical social worker who also has her LCAS. She has 16 years of experience working with adults with severe mental illness. She does not assume any significant agency role that detracts from her full-time status with this team.

fill more than one role on the team.		
CT2. Team Leader is Practicing Clinician. Definition: In addition to providing administrative oversight to the team, the team leader performs the following functions: (1) directly providing services as a clinician on the team and (2) delivering consistent clinical supervision to ACT staff.	**4**	Stella reports spending about 14 hours a week providing direct services to clients and/or natural supports, which includes seeing five clients routinely for therapy. Other data sources indicated that this estimate was accurate. She reported providing scheduled clinical supervision twice a month to the two staff most in need of supervision, which was listed as Josie and Lucy. Other data sources suggested that these estimates were accurate. Ned, the program manager who supervises Stella, also provides some clinical supervision to team members. Ned is not considered part of the team, but will at times step in to provide direct services when the team is feeling overwhelmed. We encourage Stella to consider ways to increase the rate at which she is providing clinical supervision to the team, which can also include group supervision (outside of the daily team meeting). Her level of direct clinical work meets criteria, but also may be high and resulting in less time in her administrative and supervisor roles.
CT3. Psychiatric Care Provider on Team. Definition: The team has at least 0.8 FTE psychiatric care provider time to directly work with a 100-client team. Minimum qualifications include the following: (1) qualified by state law to prescribe medications; (2) Board certified in psychiatry/mental health by a national certifying body recognized and approved by the state licensing entity; and (3) has relevant experience working with people with serious mental illness.	**5**	Dr. Owen and Marissa del Toro, a psychiatric nurse practitioner, are the team's psychiatric care providers. Dr. Owen works with the team 16 hours per week, at 0.40 FTE, and Marissa works with the team eight hours per week, at 0.20 FTE. Both meet qualifications for ACT team psychiatric care provider and have considerable experience within this role; Dr. Owen is board certified in psychiatry and Marissa has 10 years of experience working with individuals with serious mental illness, including two years of supervised work while in training. Although the team is short on nursing staff (see CT6), we did not find Marissa substituting her time in to fulfill more typical nursing responsibilities. In total, the 24 hours of psychiatric care provider time is prorated as 0.85 FTE given a 100-client team. Further, their schedules involve some overlap (Dr. Owen works Tuesday and Wednesday and Marissa works Wednesday), where the two can have consistent communication. Although the team has sufficient psychiatric care coverage by adding Marissa when growing to a midsize team, it is of concern that the team operates from Thursday – Monday without the presence of a psychiatric care provider team member. If possible, consider alternative ways to provide more psychiatric coverage to the team throughout the week while not sacrificing communication between the two.
CT4. Role of Psychiatric Care Provider (In Treatment) Definition: In addition to providing psychopharmacologic treatment, the psychiatric care provider performs the following functions in treatment:	**3**	Because Marissa works fewer hours and is the primary provider for about 1/3 of the team's caseload, we give more weight to Dr. Owen's fulfillment of the listed functions. The psychiatric care providers met all of the listed functions at least partially. In review of all 14 charts, we found that eight (57%) were seen within six weeks and one (7%) had timespans of more than

Function #1: Typically provides at least monthly assessment and treatment of client's symptoms and response to the medications, including side effects;	P	three months between face-to-face meetings with an ACT psychiatric care provider (this person was in jail). In review of data sources, we found that neither Dr. Owen nor Marissa provided brief therapy, but provided more supportive therapy. They try to keep in the loop of what other team members are doing and reinforce those strategies, but could not cite specific examples that reflected brief therapy (Function #2). Data sources indicated that a shared decision-making paradigm is practiced with the following examples: their descriptions of how they approach medication decisions highlighted the importance of understanding the person's view and experience with medications and educating them on options. The use of IMs appeared to be largely driven by client choice, with some exceptions of clients who otherwise refuse all medications (and no medications resulted in worse outcomes). They were serving two individuals who were currently refusing all medications and continued to have scheduled meetings with them to monitor and attempt to address symptoms with alternative options (e.g., one client only wants to try alternative medicine options for now) (Criterion #3). We also found that Dr. Owen and Marissa are utilizing Clozaril as part of their medication options (this medication is widely under-used and, theoretically, would be well-suited for some individuals served by ACT). Data indicated that the providers partly assumed a proactive role monitoring and addressing non-psychiatric medical conditions and medications, with the following examples: being aware of who has diabetes or is pre-diabetic, or hypertension and trying to coordinate care with other providers (Criterion #4). Along with nursing staff, they conduct routine lab work and monitor vitals. There was expressed hesitation to bridge medications and assume too active of a role around healthcare, citing concerns that clients and the team will default to them as the PCP. There is no systematic tracking of health-related data. When clients are in a psychiatric hospital, both provided many examples of direct coordination with inpatient staff, including visiting clients while hospitalized (most recent example was three weeks earlier). As with the team, both cited frustrations with inpatient staff not always appearing to value their input (Criterion #5). It appeared that both Marissa and Dr. Owen do see clients in the community (both at approximately 40%). Dr. Owen typically leaves for community visits by noon and has a few people he will see on his way in when it is their scheduled time. Marissa, too, spends most of her day in the community. We applaud the modifications the team has made in not having a nurse accompany Dr. Owen on all of his visits (Function #6)!
Function #2: Provides brief therapy;	P	
Function #3: Provides diagnostic and medication education to clients, with medication decisions based in a shared decision-making paradigm;	F	
Function #4: Monitors all clients' non-psychiatric medical conditions and non-psychiatric medications;	P	
Function #5: If clients are hospitalized, communicates directly with clients' inpatient psychiatric care provider to ensure continuity of care;	F	
Function #6: Conducts home and community visits.	F	
CT5. Role of Psychiatric Care Provider (Within Team) Definition: The psychiatric care provider performs the following functions WITHIN THE TEAM: (1) Collaborates with the team leader in sharing overall clinical	**3**	We credit Dr. Owen and Marissa for meeting all of the listed within Team Functions, except for #3, attending the majority of treatment planning meetings (they reportedly provide consultation around planning, but rarely directly attend planning sessions with client) and #4, attending daily team meetings (a team this size would require participation in at least three

responsibility for monitoring client treatment and team member service delivery; (2) Educates non-medical staff on psychiatric and non-psychiatric medications, their side effects, and health-related conditions; (3) Attends majority of treatment planning meetings; (4) Attends daily team meetings in proportion to time allocated on team; (5) Actively collaborates with nurses; and (6) Provides psychiatric back-up to the program after-hours and weekends (Note: may be on a rotating basis as long as other psychiatric care providers who share on-call have access to clients' current status and medical records/current medications).		meetings per week, whereas they only have access two days per week [Tuesday and Wednesday]). Dr. Owen works closely with Stella; the two have had a strong working relationship for the past five years, per multiple sources, and are viewed as clinical co-leaders of the team. We heard and observed examples of education with the team, including a monthly "seminar" Dr. Owen holds with the team and covers specific topics relevant to ACT (e.g., recent months he presented on akathisia and restlessness and use of Clozaril). They both appear to collaborate closely with nursing staff and provide psychiatric back-up after hours (Dr. Owen is default for his own clients and Marissa for her clients; both provide back-up for each other).
CT6. Nurses on Team. Definition: The team has at least 2.85 FTE registered nurses (RNs) assigned to work within a 100-client team. At least 1 full-time RN on the team has a minimum of 1-year experience working with adults with severe mental illness. NOTE: This item is rated based on 2.85 FTE (vs. 3.0 FTE) since there is more likelihood for the team to get penalized on this particular item if they go even slightly above the 100-client team.	**4**	Matt and Gail are the ACT team nurses, both full-time with the team. Matt is an RN who has worked with the team for the past three years and has a total of 18 years of experience working with adults with serious mental illness. Gail is an LPN and has over 10 years of experience working with adults with serious mental illness, both inpatient and outpatient. Per TMACT Rating Protocol, Gail's time is adjusted to 75% of the FTE, or 0.75 FTE, as LPNs have a more limited scope of practice. In total, the team has a total of 1.75 nursing FTE, which is prorated to 2.46 FTE given a 100-client team.
CT7. Role of Nurses. Definition: Team nurses perform the following critical roles (in collaboration with the psychiatric care provider):	**4**	We credit nursing staff for all listed functions at least partially. Nursing staff are partially credited for managing the medication system, which includes administering and documenting medication treatment. In review of the level of medication supports provided by nursing staff, we found that few (20%) clients receiving oral medications are either managing oral medications on their own (e.g., picking up from pharmacy, or delivered by pharmacy with little immediate intersection from nursing) or receive significant oversight from residential staff. We observed mixed evidence for nursing staff assuming a proactive role in screening and monitoring clients for medical problems/side-effects. Nursing staff complete a nursing assessment near intake, but this assessment is not routinely updated throughout enrollment. Nursing staff, along with psychiatric care providers, assess vitals, but there was not a clear and consistent occasion for when vitals are assessed, nor was there any tracking of age-related health screens (Function #2). Data indicated strong support for the nursing staff role in communicating and coordinating services with other medical providers; the nurses have divided the caseload, so each assumes more responsibility for a subset of the caseload. Nursing staff
Function #1: Manage the medication system, administer and document medication treatment;	F	
Function #2: Screen and monitor clients for medical problems/side effects;	P	
Function #3: Communicate and coordinate services with the other medical providers;	F	
Function #4: Engage in health promotion, prevention, and education activities;	P	

Function #5: Educate other team members to help them monitor psychiatric symptoms and medication side effects;	F	had many recent examples of accompanying individuals to doctor and dental appointments and provided examples of a health communication form they routinely use to share information with other providers. Examples of nursing staff engaging in health promotion, prevention, and educational activities indicated less consistent practice (Function #4), with most examples focused on diabetes management (we did not observe examples related to nutrition, exercise, or safe sex practices). We heard examples of nursing staff providing education to team members, such as how to use a glucose monitor, side-effects to watch for with a new medication, and how to assist with redressing a wound for a client. For those clients willing to take medications but not consistently doing so, nursing staff have assisted with medication adherence using the following strategies: setting up alarms, identifying morning behavioral patterns and integrating medications into routine, using team phone call reminders, modifying packaging to be more visually clear, modifying timing of medications. These examples were judged to be robust, therefore resulting in full credit for Function #6.
Function #6: When clients are in agreement, develop strategies to maximize the taking of medications as prescribed.	F	
ST1. Co-Occurring Disorders Specialist on Team Definition: The team has at least 1.0 FTE team member designated as a co-occurring disorders specialist, who has at least a bachelor's degree and meets local standards for certification as a substance abuse or co-occurring specialist. Preferably this specialist has training or experience in integrated dual disorders treatment.	**5**	Josie Crane is designated as the team's Co-Occurring Disorders Specialist. Josie is full-time with the team and meets minimal qualifications as she has her MSW, LCAS, and five years of experience working with this population. Josie estimated that approximately 90% of her contacts involve a co-occurring disorders (COD) service relevant to specialty area. Other data sources supported this estimate; she is the primary or on the ITT for 22 individuals, all of whom have a COD, and we found that nearly all (86%) of her progress note entries reviewed in the chart sample reflected some COD intervention. Of note, although we do not count her effort here, Stella, the team leader, is also a LCAS and provides some direct care to clients.
ST2. Role of Co-Occurring Disorders Specialist in Treatment. Definition: The co-occurring disorders specialist provides integrated dual disorders treatment to ACT clients who have a substance use problem. Core services include:	**4**	We fully credit Josie for all listed services except for Service #1, which received partial credit. In review of the charts and interview data, it appeared that the extent to which substance use is assessed, especially in relationship with mental health, is occurring near the time of enrollment by Josie. The assessment tool she is using appeared to gather helpful information and examined the interrelationship between substance use and mental health. She reported that she is trying to complete it within the first six months of clients' enrollment. There is a follow-up assessment available, but we found that it was inconsistently completed per our review of charts. Stages of change readiness are being assessed and documented in progress notes, stand-alone SUDs filed in charts, and tracked by way of a document used in the daily team meeting. Josie leads the team monthly in a staging discussion where they review about four clients at a time, updating their stages of change readiness and, more importantly, discussing strategies and interventions. Application of motivational interviewing techniques and use of strategic outreach with those in earlier stages of change readiness were clearly evident. Josie is
Service #1: Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health;	P	
Service #2: Assessing and tracking clients' stages of change readiness and stages of treatment;	F	

Service #3: Using outreach and motivational interviewing (MI) techniques;	F	on the ITT for several clients in earlier stages of change readiness. In describing MI-related techniques, she was able to provide specific examples in how she has worked with these individuals, including focusing on basic needs, keeping attention on understanding what mattered most to people and finding gentle ways to explore how behaviors help or hinder those goals. She carries scaling tools with her to help use visuals in these discussions. Understanding and applying CBT approaches, especially in context of substance use counseling and relapse prevention, was also evident. She helps clients complete and use relapse prevention plans, assist people who are interested locate and attend self-help groups, and co-facilitate a weekly substance use counseling group with Stella, targeting those in action and maintenance stages of change. In review of data sources, it appears that she is consistently applying strategies according to the clients' stages of change readiness.
Service #4: Using cognitive behavioral therapy (CBT) approaches and relapse prevention;	F	
Service #5: Applying treatment approaches consistent with clients' stage of change readiness;	F	
ST3. Role of Co-Occurring Disorders Specialist within Team. Definition: The co-occurring disorders specialist is a key team member in the service planning for clients with dual disorders. The co-occurring disorders specialist performs the following functions WITHIN THE TEAM: (1) modeling skills and consultation; (2) cross-training to other staff on the team to help them develop dual disorders assessment and treatment skills; (3) attending all daily team meetings; and (4) attending majority treatment planning meetings for clients with dual disorders.	**4**	We credit Josie in meeting all of the listed Within Team Functions except for Functions #4. She is attending all daily team meetings and we heard and observed examples of her providing consultation and modeling, such as around stage-appropriate approaches and interventions. She recently provided cross-training on potency of marijuana on the street and issues related to synthetic marijuana. The team is inconsistent in how planning meetings are conducted; most clients have a planning meeting annually that includes the ITT members, then interim six-month meetings with just the primary care provider on the ITT.
ST4. Employment Specialist on Team. Definition: The team has at least 1.0 FTE team member designated as an employment specialist, with at least one year of experience providing employment services (e.g., job development, job coaching, supported employment). Ideally, the ACT employment specialist is a part of a larger supported employment program within the agency.	**2**	John Parker is designated as the team's Employment Specialist. John is full-time with the team but does not meet minimal qualifications at the time of review. John's training has been in social work and of the various jobs he has held, none have been specific to employment services. He was hired into this position approximately six months ago. Both he and Stella spoke to his positive attitude and eagerness to help people return to work. There is no other employment program at County, but he has gotten together with the County West ACT team Employment Specialist on two occasions. He has attended local IPS trainings in the past three months. John estimated that approximately 60% of his time involved an employment and education service. Other data sources did not support this high of an estimate; 38% of John's progress note entries reflected employment services and the rate at which he is doing any job development activities is moderate. In review of his assignment to ITTs, he counted 20 individuals. Of those individuals, it appeared that six of them were unclear what employment

		service he was delivering. We therefore adjusted to 50%, reflecting a 0.60 FTE, which tentatively rates a "3," but is further reduced due to John not yet meeting the qualifications standard.
ST5. Role of Employment Specialist in Services Definition: The employment specialist provides supported employment and education services. Core services include:	**2**	John appears eager to assume this role despite his lack of training in employment an education services. Attitudinally, we heard and observed an embrace of the value of work–competitive work–as part of individuals' recovery, but also some hesitation for those viewed as possibly too symptomatic to work. In review of charts and interview data, efforts to engage individuals in considering competitive employment and education as a personal goal or objective were inconsistent and appeared dependent on John's evaluation of the person's abilities to work (e.g., relatively well-managed symptoms, personal hygiene skills). Further, how John is scheduled does not fully support utilizing him in this effort to strategically engage clients (an issue that undercuts practice in several areas). In examining charts and seeking examples of assessments, we found that there is limited assessment of vocational history and interests in the intake, with no stand-alone assessment conducted in a more timely and ongoing manner. Further, John is not the one conducting any assessment beyond the highly informal questioning and notes he takes when working with someone who is wanting a job (John is aware of the Career Profile, but was not sure if his agency allowed him to use it so he recalled questions from the Profile when conducting his own very informal assessments). Regarding job development, examples provided indicated that there has been concerted efforts to outreach to local employers to understand needs and develop relationships, but this has been a relatively new practice and John is continuing to develop his skills (he has attended several IPS-related trainings that covered job development). He offered a log for our review that showed seven employers he has approached (two more than one time) in the past four weeks. Majority were in the service industry. When asked about his pitch, John provided a nice opening that focused on his role trying to both help people return to work and get to know employers' needs and struggles to see how he can be of help. The jobs that clients get hired into also do not consistently appear to reflect a person-centered approach and the pace at which the employment specialist assists clients interested in working does not appear to meet "rapid placement" criteria, where there is typically fewer than 30 days between expression of interest and first contact with an employer. In review of the information provided, half of those in competitive employment (four of eight) reportedly got the job on their own and the ones with assistance were highly concentrated in Walmart. Conversely, client and staff interview data spoke to John's effort to find a right-fit job and he was working with one woman to access equipment to set up her own tattoo business. Once employed, the types of follow-along
Service #1: Engagement;	P	
Service #2: Vocational assessment following SE principles;	N	
Service #3: job development;	P	
Service #4: job placement (including going back to school, classes);	P	
Service #5: job coaching & follow-along supports (including supports in academic settings);	N	
Service #6: benefits counseling	N	

		supports provided by John included periodic check-ins with other staff in the daily team meeting or in-person if John is scheduled to see those individuals. There were no reports of job coaching or more strategically planned and delivered follow-along supports to address emerging, anticipated, or current challenges. Benefits counseling is very minimally provided by John, who shared that he knows little about how work impacts benefits and work incentive programs.
ST6. Role of Employment Specialist within Team Definition: The employment specialist is a key team member in the service planning for clients who want to work or are currently working. The employment specialist performs the following functions WITHIN THE TEAM: (1) modeling skills and consultation; (2) cross-training to other staff on the team to help them to develop supported employment approaches with clients in the team; (3) attending all daily team meetings; and (4) attending majority treatment planning meetings for clients with employment goals.	**3**	We credit John for meeting two Within Team Functions. He provided cross-training to the team following an IPS training he attended, where he educated team on job development, including ways they can assist with job development activities. The team reported increased efforts to observe and share job openings posted and efforts to approach and gather more information from employers. This training was held three months ago. John also routinely attends the daily team meeting. Although his participation in the employment specialist role could be improved, we were able to identify him as being in this role by way of his exchanges. We do not credit him for attending most of the planning meetings for those with employment goals, nor do we credit him for consulting and modeling. John's understanding and practice of evidence-based supported employment is still in early development. Team member interviews did not support crediting him in a role as a team expert.
ST7. Peer Specialist on Team. Definition: The team has at least 1.0 FTE team member designated as a peer specialist who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following: (1) self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) is in the process of his/her own recovery; and (3) has successfully completed training in wellness management and recovery interventions.	**1**	At the time of the review, the team's Peer Specialist position was vacant for one month and the team was actively recruiting to fulfill this position.
ST8. Role of Peer Specialist. Definition: The peer specialist performs the following functions:	**N/A**	Per TMACT protocol, we do not rate the team on this item given that the position has been vacant for less than six months.
Function #1: Coaching and consultation to clients to promote recovery and self-direction		
Function #2: Facilitating wellness management and recovery strategies		

Function #3: Participating in all team activities equivalent to fellow team members		
Function #4: Modeling skills for and providing consultation to fellow team members		
Function #5: Providing cross-training to other team members in recovery principles and strategies		
CP1. Community-Based Services. Definition: The team works to monitor status and develop skills in the community, rather than in office. Team is oriented to bringing services to the client, who, for various reasons, has not effectively been served by office-based treatment.	**5**	Of the 14 charts randomly selected for review where there was at least one face-to-face contact, the average (median) rate at which services were provided in the community (vs. the office) was 100%.
CP2. Assertive Engagement Mechanisms. Definition: The team uses an array of techniques to engage difficult-to-treat clients. These techniques include:	**4**	In efforts to engage individuals who clearly need ACT but are actively or passively resisting or refusing services, the following strategies were provided or observed: team focuses on what the client is wanting (e.g., food, housing, help getting Social Security benefits, dissolving guardianship) and tries to avoid topics that appear to be clear triggers (e.g., medications, substance use, personal hygiene). Specific client examples were shared, which includes caring and persistent outreach efforts. The team has access to a petty cash fund that they use in several ways, including offering tangible items to enhance the attractiveness of a visit (e.g., bringing by $10 grocery cards; Gatorade; socks). We also heard nice examples of the team appearing to appropriately resort to therapeutic limit-setting strategies, including leveraging power of a family member guardian or court order. They provided examples of the team deciding to initiate a pick-up order for involuntary commitment and have worked closely with representative payeeships to help increase service engagement. In review of rating criteria, we found that the team met full credit criteria for motivational interventions and full credit for therapeutic limit-setting strategies. Of note, skillful teams should be willing and prepared to use therapeutic limit-setting strategies, but are adept at creative, person-centered motivational approaches where therapeutic limit-setting is needed less often. Data did not, however, indicate that a reliable process is in place for assessing the success of engagement strategies, where this information is used to determine necessary changes in intervention strategies. We encourage the team to utilize the current "dashboard" on the daily team meeting as part of this process.
Practice #1: Motivational interventions;	F	
Practice #2: Therapeutic limit-setting;	F	
Practice #3: Thoughtful application and withdrawal of engagement practices	N	

CP3. Intensity of Services. Definition: The team delivers a high amount of face-to-face service time as needed.	**4**	To rate this item, we calculated the average weekly time spent with each of the 14 clients selected for chart review. A four-week period was reviewed. The mean times across the 14 charts were rank-ordered and the median duration was calculated to avoid bias of outliers (i.e., extremely high ACT service users or low service users). We found that, on average, staff spent 95 minutes each week with clients, which results in a "4" rating.
CP4. Frequency of Contact. Definition: The team delivers a high number of face-to-face service contacts, as needed.	**3**	The team averaged 1.8 face-to-face contacts per week per client during the four weeks sampled for this review. As with item CP3, we rank ordered the 14 client charts by average number of weekly contacts and then calculated the median, which controls for both high and low outliers. On the lower end, one client was seen only two times, but had three attempts by the team that month. On the higher end, three clients were seen five to seven times per week by the team. The reason for these visits appeared to be largely driven by medication and symptom monitoring.
CP5. Frequency of Contact with Natural Supports Definition: The team has access to clients' natural supports. These supports either already existed, and/or resulted from the team's efforts to help clients develop natural supports. Natural supports include people in the client's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy).	**2**	Per the team's report, approximately 25 of the 71 enrolled clients (or 35%) have natural supports with whom the team has had contact with in the past month, resulting in a "2" rating.
CP6. Responsibility for Crisis Services. Definition: The team has 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria:	**4**	The team does operate an on-call crisis services line (Criterion #1) and calls coming in are immediately received by the team (Criterion #2). The team rotates the on-call responsibility across all staff on a weekly basis with the team leader and psychiatric care providers available as back-up and support. In review of crisis plans, we found that three of six (50%) were judged to be practical and individualized and that team members do have access to crisis plans when on-call. Although we hope for it not to be a frequent event when delivering proactive and planful services, the team's willingness to address crises in person outside of typical 1st shift hours was indicated, with two relatively recent examples provided (one where team member met the client at the hospital admission at 9pm and another where the on-call staff, Stella, and client's mother met with the client at her residence while in distress and reporting suicidal thoughts).
Criterion #1: The team is available to clients in crisis 24 hours a day, 7 days a week;	F	
Criterion #2: The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging);	F	
Criterion #3: The team accesses practical, individualized crisis plans;	P	
Criterion #4: The team is able and willing to respond to crises in person, when needed	F	

CP7. Full Responsibility for Psychiatric Services Definition: The team assumes responsibility for providing psychiatric services to clients, where there is little need for clients to have to access such services outside of the team. The psychiatric care provider assumes most of the responsibility for psychiatric services. However, the team's role in medication administration and monitoring are also considered in this assessment, especially when evaluating psychiatric services provided to clients residing in supervised settings where non-ACT staff also manage medications; the expectation is that ACT staff play an active role in monitoring medication management even when a client is in a residential setting.	**5**	It is assumed that at least 90% of people served by ACT will need some type of psychiatric services from the team. The team reports that all (100%) clients are receiving psychiatric services directly from the team, which includes meeting with Dr. Owen and Marissa. We did not further adjust this item as the team had very few (10%) clients currently living in residential settings where residential staff provide medications. In these residences, ACT nursing staff are routinely checking MARs and group home records. Also, no adjustment was made due to psychiatric care providers having infrequent follow-up; most are being seen approximately monthly and no one is seen less frequently than every three months (with one exception of a person in jail). Thus, 100% + (100%/90%) was calculated for this item, resulting in a "5" rating.
CP8. Full Responsibility for Psychiatric Rehabilitation Services. Definition: The team assumes responsibility for providing psychiatric rehabilitation services to clients, where there is little need for clients to have to access such services outside of the team. Psychiatric rehabilitation services include social and communication skills training and functional skills training to enhance independent living (e.g., activities of daily living, safety planning, transportation planning/navigation skill building, and money management). The delivery of these services should be based on an initial assessment of functional deficits, followed by deliberate and consistent skills training which typically includes staff demonstration, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings.	**3**	It is assumed that at least 90% of clients served by an ACT team will benefit from psychiatric rehabilitation interventions that involve functional skill-building. The team reported that 55 of 71 (77%) clients were receiving psychiatric rehabilitative interventions from the team. In review of 14 charts, we found evidence of any such psychiatric rehabilitation in eight charts (57%) and when looking at those that were judged to reflect a higher quality example, 50% met that criteria and 75% were systematic (a psychiatric rehabilitation intervention was delivered more than one time in a four-week period). When we looked explicitly at the sampled charts of clients the team endorsed as getting psychiatric rehabilitation from the team, we found that seven of those 10 charts, 70% had documentation indicating this service. Further, interview data provided several examples of psychiatric rehabilitation, but in some ways limited to budgeting, grocery shopping, and cooking (no examples related to social skill development, grooming and hygiene, mobility and leisure). Given this information, the team's original report was not fully supported. Following rating guidelines, we adjust the team's original report down to 65% of clients receiving psychiatric rehabilitation from the team. The resulting service rate is 72% (65%/90%), rating a "3."

EP1. Full Responsibility for Integrated Treatment for Co-Occurring Disorders. Definition: The team assumes responsibility for providing integrated treatment for co-occurring disorders within ACT, where there is little need for clients to have to access such services outside of the team. Core services include systematic and integrated screening and assessment and interventions tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing) and later stages of change readiness (e.g., CBT, relapse-prevention). It is expected that the ACT Substance Abuse Specialist will assume the majority of responsibility for delivering DD treatment, but ideally other team members also provide some DD services. Integrated treatment for co-occurring disorders reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	**5**	The team reported that 42 of the 71 clients (59%) have a comorbid substance abuse disorder, which is consistent with rates found in research. The team reported that 41 (58%) clients are consistently receiving individual and/or group integrated co-occurring disorders (COD) treatment from the team (one client has been in jail for past two months). In review of 14 charts, we found evidence of integrated COD treatment in seven charts (50%) and when looking at those that were judged to reflect a higher quality example, 71% met that criteria and 86% were systematic (a COD intervention was delivered more than one time in a four-week period). Of note, the random sample included eight charts (57%) of individuals the team endorsed as getting COD services from the team, a representative sample. Further, interview data provided many examples, such as providing a weekly substance abuse group (topics included coping skills to work through cravings and review of various self-report groups in areas), various team members using harm reduction strategies for those actively using, and supporting individuals as they are in a period of abstinence. Given this information, the team's original report was supported. The resulting service rate is 98% (58%/59%), rating a "5."
EP2. Full Responsibility for Employment and Educational Services. Definition: The team assumes responsibility for providing employment and education services to clients, where there is little need for clients to have to access such services outside of the team. Core services include engagement, vocational assessment, job development, job placement (including going back to school, classes), and job coaching & follow-along supports (including supports in academic/school settings). It is expected that the ACT Employment Specialist will assume the majority of responsibility for delivering supportive employment and education services, but ideally other team members also provide some of these services.	**3**	It is assumed that at least 40% of clients served by an ACT team want employment and education services. The team reported that 28 of 71 (39%) clients were receiving such services from the team. In review of 14 charts, we found evidence of supported employment and education services in three charts (21%) and when looking at those that were judged to reflect a higher quality example, 33% met that criteria and 33% were systematic (a supported employment or education service was delivered more than one time in four-week period). Looking only at those sampled charts the team endorsed, we found that six such charts were sampled and only three (50%) had any documentation of employment or education services. Given all this information, the team's original report was not supported. Following rating guidelines, we adjust the team's original report down to 20% of clients are receiving supported employment and education services from the team. The resulting service rate is 50% (20%/40%), rating a "3."

EP3. Full Responsibility for Wellness Management and Recovery Services. Definition: The team assumes responsibility for providing wellness management and recovery (WMR) services to clients, where there is little need for clients to have to access such services outside of the team. These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. Examples of such services include the development of Wellness Recovery Action Plans (WRAP) and provision of the Illness Management and Recovery (IMR) curriculum.	**3**	It is assumed that at least 20% of clients served by an ACT team want a manualized wellness management and recovery service, which may include Wellness Recovery Action Plan (WRAP), Illness Management and Recovery (IMR), or other more manualized and studied approaches. The team reported that seven of 71 (10%) clients were receiving such services, particularly from Lucy Strong, the team's therapist, who had been trained in helping people develop WRAPs (and previously co-facilitated a WRAP group with former Peer Specialist). In review of 14 charts, we sampled two charts of individuals the team endorsed as receiving this service and indeed saw evidence of such in both charts. Further, client interview data supported not only Lucy's assistance with WRAP, but other team members reinforcing information in clients' plans. Given this information, the team's original report was supported. The resulting service rate is 50% (10%/20%), rating a "3."
EP4. Integrated Treatment for Co-Occurring Disorders Definition: The FULL TEAM uses a stage-wise treatment model that is non-confrontational and the FULL TEAM:	**4**	The implementation of integrated treatment for co-occurring disorders within the team was evident. Across data sources, we observed clear evidence for the team attending to the interaction of mental health symptoms and substance use. In one example staffed in the daily team meeting, team members had "parked" one client for further discussion and reviewed what they knew to be reinforcing current drug using behaviors (certain people she was hanging with, current isolation from family, numbing effects, access to money). With prompting, interviewed team members could easily recount related stories of randomly selected clients from the list. The team appears to fully apply harm reduction tactics, providing a range of examples (e.g., clean needle exchange, working with a man to drink in private at home to avoid fights and legal problems, helping find a one-story living situation to help reduce chance of falls for one man, reducing amount and potency of substances). The team annually brings in trainers from the local Harm Reduction Coalition to keep the team abreast of harm reduction strategies. Dr. Owen and Marissa had examples of using psychopharmacological interventions to help with cravings, prescribed naltrexone, and supported one client on Methadone. Both are careful in prescribing potentially addictive medications. Evidence for the team both understanding and applying stages of change readiness information in practice was also relatively strong. Josie is doing a good job, supported by Stella and Dr. Owen, in leading more systematic discussions about stages of change, which appeared to infuse the language of this team. Overall, we found the team to be well-versed in common motivational interviewing language, but inconsistent in practice. The team has such a solid foundation here that we strongly encourage the agency to find a Motivational Interviewing Network Trainer (MINT) to provide team-supervision. Finally, when examining the team's use of CBT techniques, particularly for those needing more active
Criterion #1: Considers interactions between mental illness and substance abuse;	F	
Criterion #2: Does not have absolute expectations of abstinence and supports harm reduction;	F	
Criterion #3: Understands and applies stages of change readiness in treatment;	F	
Criterion #4: Is skilled in motivational interviewing (MI);	P	
Criterion #5: Follows cognitive-behavioral therapy (CBT) principles	F	

		substance use counseling and relapse prevention, evidence was also strong. Overall, we found the team actively working with people who were working on sustaining abstinence. Several team members shared stories of assisting people to find a good-fit self-help group, helping people create and use relapse prevention plans, assessing and addressing precipitators for use, and coping skill techniques.
EP5. Supported Employment and Education (SEE) Definition: The FULL TEAM embraces and practices for an evidence-based supported employment model, as evidenced by the following criteria:	**3**	Across data sources, we observed inconsistent evidence for the team valuing competitive work as a goal for all clients. Although John and other team members were supportive of work and articulated work's role in a person's recovery, the team was lacking in strong champions for competitive employment specifically (versus encouraging activities to provide structure and meaning, which includes volunteer work). The team appears to partly value a person's expressed interest in working as the primary criteria for eligibility for supported employment services through ACT. Some interviewed staff shared concerns about the severity of symptoms, anticipating they would interfere with employment too much. In contrast, other staff did not appear to hold such beliefs and cited practice examples to the contrary (e.g., working with a woman with very active and disruptive hallucinations find employment in loud machine repair shop). Also, the team was fairly in agreement that active substance use was not something that would give them pause in assisting someone in employment. As for Criteria #3, we did not hear examples of overt intermediate assessment steps clients are expected to take before provided help moving towards competitive employment. There was a clear mixed approach across team members in how much they valued gathering the most critical information and moving clients along promptly towards active job seeking. One interviewed team member expressed regret the team can no longer refer clients to local vocational rehabilitation for more lengthy assessment. Team practices appear to partly support individualized placements that reflect the person's preferences for work and practices in a manner that does not result in significant delays in contacting employers. Although most clients currently working were working at Walmart, we did observe several practice examples of the team working to support clients find employment best fitting with interests. As for pace of movement, it seemed to depend in part on who the primary care team member was (some were more active than others) and what role John assumed in services (on occasion, if John was looped in, he may move quickly to help with finding employers). Evidence for the team's practices in providing deliberate and ongoing supports to assist people in keeping employment were not evident. In addition to the team not offering any on-site job coaching, we heard very few examples of team members providing services strategically to support people in keeping employment, which could include offering assertiveness training, relaxation skills to practice during breaks, and time management
Criterion #1: Values competitive work as a goal for all clients;	P	
Criterion #2: Believes and supports that a client's expressed desire to work is the only eligibility criterion for SE services;	P	
Criterion #3: Believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment;	P	
Criterion #4: Believes and supports that placement should be individualized and tailored to a client's preferences;	P	
Criterion #5: Believes that ongoing supports and job coaching should be provided when needed and desired by client	N	

		strategies. The absence of the team developing and using Career Profiles is likely having a significant impact on overall practice.
EP6. Engagement and Psychoeducation with Natural Supports. Definition: The FULL TEAM works in partnership with clients' natural supports. As part of their active engagement of natural supports, the team**:**	**3**	Overall, we found the team's work with natural supports to be inconsistent. In review of multiple data sources, examples of the team providing psychoeducation to clients' natural supports were often reactive to current crises. We did hear a nice example from Josie regarding educating the families of two clients about their mental health and substance use. Similarly, Dr. Owen and Marissa had stories related to those with COD. Examples of team members assuming a role around problem-solving tended to also reflect reactive efforts when clients are in crises or generally natural supports reaching out to the team for assistance. Stella expressed interest in learning how to facilitate family psychoeducation groups as well as acknowledgement that the team could do much better attending to the social needs of clients in general, which includes helping them connect with natural supports. Finally, the team does help natural supports access local support groups, such as NAMI and Al-Anon. The team keeps materials in the lobby. One client's mother is active in the local NAMI Chapter and Stella is in frequent contact with her, including presenting to NAMI on ACT four months ago.
Strategy #1: Provides education about their loved one's illness;	P	
Strategy #2: Teaches problem-solving strategies for difficulties caused by illness;	P	
Strategy #3: Provides &/or connects natural supports with social & support groups	F	
EP7. Empirically-Supported Psychotherapy Definition: The team offers empirically supported psychotherapy to select clients who would benefit from such approaches. The team meets the following criteria:	**4**	We evaluate whether the team has at least one licensed therapist providing deliberate psychotherapy to clients or whether the team is adept at core therapeutic techniques. In addition to Stella, a licensed therapist, Lucy is the team's licensed therapist. Several team members also appeared clinically adept in their use of CBT techniques. For Criterion #2, we are evaluating the extent to which data sources indicate that the team clinicians and/or broader team are skillful in using evidence-based practices, particularly CBT. We found that to be the case; Lucy shared a range of materials she has been using in her work, consistent with CBT materials. She and the team have received training in trauma-informed care, but shared she is not trained in trauma-specific therapies and has referred out to another non-ACT team therapist for a handful of clients with significant trauma. Per the team report, 19 (27%) clients have received deliberate and planned empirically-supported psychotherapeutic interventions from the team in the past year.
Criterion #1: deliberately provides individual and/or group psychotherapy, as specified in the treatment plan	F	
Criterion #2: uses empirically-supported techniques to address specific symptoms and behaviors	F	
Criterion #3: maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services.	P	
EP8. Supportive Housing. Definition: The team embraces the supportive housing model, including:	**4**	The percent of clients who are living in settings where at least 25% of the units/rooms are designated for tenants who meet disability related eligibility criteria (Criterion #1) was reported

Criterion #1: Client Choice: clients typically live in housing of their choice (e.g., ideally living in residences typical of the community, without clustering people with disabilities and/or other special needs such as homelessness). Such community integration is assumed to reflect the team's efforts to assist clients to find housing of their choice. The percent of clients living in settings where at least 25% of the units/rooms are designated for and/or occupied by tenants who meet disability related eligibility criteria: is 26% - 69% (Partial Credit) or is less than 25% (Full Credit).	F	to be 14% by the team. Many of these individuals appeared to be living in congregate apartment-type settings, smaller adult foster care placements, and group homes. At the time of the review, two people were reported to be street homeless and the team was actively working with them to secure housing. We observed no instances where clients did not have control over whether staff entered their residence; for those in supervised settings, staff worked to ensure their visits were by invitation of the client. The percent of clients who are receiving a housing subsidy, on a waitlist for such a subsidy, or paying less than 30% of income on housing, all of which is judged to be safe and decent (Criterion #3) was reported to be 67%. The percent of clients living in housing where treatment is a condition of the lease (Criterion #4) is 10%, which only reflected those in supervised settings where they did not have to work with the ACT team but needed to be enrolled with a service provider.
Criterion #2: Privacy: clients have control over whether and when staff enter their residence. ACT staff may not enter the client residence unless client invites them or if team has reason to believe the client is in crises and/or has advanced directive for mental health conditions or other high needs. NO PARTIAL CREDIT OPTION;	F	
Criterion #3: Affordable, safe, decent housing: The team makes an effort to assist clients in accessing affordable and safe housing, as indicated by the total percent who are receiving a housing subsidy, on a waitlist for such a subsidy, or paying less than 30% of income on housing, all of which is judged to be safe and decent. The proportion of clients who are living in (or waitlisted to live in) affordable and safe housing is between 26% - 74% (Partial Credit) or at least 75% (Full Credit)	P	

Criterion #4: Tenancy rights: The degree to which tenancy is contingent on participation in ACT or other services: client-tenants are required to participate in ACT services, but failure to do so does not lead to eviction OR client-tenants are required to participate in some service program, not necessarily ACT (Partial Credit); or tenancy is not contingent in any way upon their progress or success in ACT service (i.e., tenancy may be contingent on very basic contact with outreach program for the purpose of very minimal monitoring and engagement opportunities) (Full Credit).	F	
PP1. Strengths Inform Treatment Plan. Definition: The Team practices from a strengths model, as evidence by meeting the following criteria:	**4**	Of the six charts reviewed more qualitatively, five (83%) were judged to have assessed client strengths where the documented strengths were clearly personal and relatively exhaustive (e.g., kind to others, good cook, resourceful, strong-willed, attends to details, enjoys music, good memory, no major physical health concerns – all for one client). One reviewed chart was much more limited and documented "strengths" tended to reflect more provider-valued attributes, such as "attends appointments, takes medications, engaged in treatment." Overall, we found the team to intermittently emphasize clients' strengths in their broader work, including team discussions. In assessing the extent to which strengths are informing treatment planning, we found that three (50%) of reviewed charts incorporated these strengths into goals, objectives, and/or planning of interventions. With the example client above, this client was seeking to become more socially engaged and have a best friend. The team did a good job of integrating strengths by planning for social skill interventions that involved asking questions of people to get to know them, practicing ways to bring those "things learned" about someone back into conversation when meeting again. They are also exploring avenues related to her interest in food and music, which includes employment.
Criterion #1: The team is oriented toward clients' strengths and resources.	F	
Criterion #2: clients' strengths and resources inform treatment plan development.	P	
PP2. Person-Centered Planning. Definition: The team conducts treatment planning according to the ACT model using a person-centered approach, including:	**3**	We rated this item given data collected from review of plans, interview data, and observation of a planning meeting. Plans come to be created by the primary care coordinator within the team assigned to work with the client. All clients are assigned a primary team member, one additional

Element #1: development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting)	P	team member, and one nurse. The primary, chosen typically because of the client's major focus and need, then meets with the client to review/develop the plan. The Individual Treatment Team (ITT; in this case, the two team members and nurse) will meet with the client annually for a broader discussion about goals and progress. This process was instituted approximately five months ago (Criteria #2 and #3). As far as efforts to gather relevant assessment and treatment planning data leading up to this meeting, we did not find evidence this is occurring consistently. We observed processes where the team has some brief discussion about a client and upcoming plan (sharing updates on goals, needs, brainstorming on possible interventions), but this was informally interwoven into the daily team meeting and when asking about other clients who recently had planning meetings, it did not appear to be a consistent process. Odeleen appeared to be doing a good job of alerting team members that plan due dates are approaching by giving them adequate time to prepare (Criteria #1). Efforts to help clients understand their roles in planning and ensure their voices remain the focus of planning were inconsistent across sources. In the one meeting we observed, where the client was in attendance along with Lucy (primary), Dave, and Matt (RN), no one clearly assumed a role to help provide coaching and support to the client to ensure that his voice was being heard. Several times, the client nodded or responded with "I don't know," where there was opportunity to pause, take a break, offer some reflections, and prompt client to offer more input. Although the staff did a nice job drilling down further around issues related to the client's father (which seemed to be important to the client), there were moments where team members' agendas seemed to drive the meeting (e.g., conversation related to diabetes management). In review of the content of plans themselves, they variably appeared to capture and reflect the client's preferences and wishes, with some plans being very good in this manner and others lacking considerably. It appeared that the quality of plans relied heavily on the skills of the primary team member developing the plan (Criterion #5).
Element #2: conducting regularly scheduled treatment planning meetings	F	
Element #3: attendance by key staff, the client, and anyone else s/he prefers, tailoring number of participants to fit with the client's preferences	P	
Element #4: provision of guidance and support to promote self-direction and leadership within the meeting, as needed	P	
Element #5: treatment plan is clearly driven by the client's goals and preferences and is structured in a manner to inform person-centered practices	P	
PP3. Interventions Target Broad Range of Life Domains Definition: The team attends to a range of life domains (e.g., physical health, employment/education, housing satisfaction, legal problems) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in treatment plans and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs.	**3**	Of the six client charts reviewed more thoroughly, the team was judged to have addressed in the person-centered plans at least three life domains in 67% of the charts and at least two life domains in 100% of the charts (Criterion #1). Likewise, they were judged to have provided services that addressed at least three life domains in 33% of the charts and at least two life domains in 67% of the charts (Criterion #2). In comparing what was planned for and what was delivered, the evaluators found that three of the six charts (50%) had such alignment.

Criterion #1: The team specifies interventions that target a range of life domains in person-centered plans. - 30-64% of plans reviewed have interventions targeting at least 3 life domains identified above OR at least 65% of plans have interventions targeting at least 2 life domains (Partial Credit); At least 65% of person-centered plans reviewed have interventions targeting at least 3 life domains identified above. (Full Credit)	F	
Criterion #2: and these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs. Approximately half of all clients (30-64%) receive interventions targeting at least 3 life domains identified above OR at least 65% of plans have interventions targeting at least 2 life domains. (Partial Credit). Nearly all clients (65% of charts reviewed) receive interventions targeting at least 3 life domains identified above. (Full Credit)	P	
There is alignment between practices that are planned for and carried out, with at least 60% of the charts having some appreciable continuity between planned interventions (Criterion #1) and implemented interventions. No /Yes (Alignment can impact ratings for anchors "4' and "5").	N	
PP4. Client Self Determination and Independence Definition: A high-fidelity ACT team promotes clients' independence and self-determination by:	**3**	The team's approach to actively promoting clients' self-determination and independence is examined across data sources. Our review of data found that the team inconsistently helps people make meaningful informed choices in their lives (Criterion #1). Where this came through most prominently as an issue is around employment and school, but also at times related to choices in which they were living. Conversely, we observe the team to do a nice job of helping clients make informed choices related to their substance use. It appeared that the team honors client's day-to-day decisions, thereby exercising restraint in directing client behaviors viewed as potentially problematic and instead approaching with respect and therapeutic skillfulness (Criterion #2). Finally, we found the team varies in the extent to which
Practice #1: helping clients develop greater awareness of meaningful choices available to them;	P	
Practice #2: honoring day-to-day choices, as appropriate;	F	

Practice #3: teaching clients the skills required for independent functioning. Team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.	P	they are proactive in both helping people acquire independent living skills to be more self-reliant, but also "right-fits" supportive services given the client's apparent needs (Criterion #3). We found some clients would benefit from more frequent oversight and support, including what is provided by the medical team. Although we observed some nice examples of psychiatric rehabilitation, we found many areas in need of greater attention to help people be more independent, including greater attention to social skills, relationships, and addressing boredom. As noted earlier, enlisting clients more in the planning process and hiring and using a Peer Support Specialist will also bolster the team's work. Relatedly, the team's limited work with clients' natural supports, or citing that many do not have natural supports, lends to problems supporting clients in being more self-determined and independent.

Appendix E. DACTS-TMACT Crosswalk

CRITERION		RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)	TMACT DATA SOURCE
HUMAN RESOURCES: STRUCTURE & COMPOSITION							
H1	SMALL CASELOAD: client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	11 - 20	10 clients/clinician or fewer	Refer to Team Survey Items #1 and #7; or TMACT Item OS1
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 36%.	37 - 63%.	64 - 89%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.	Refer to Chart Review Tally Sheet, Team Approach Column
H3	PROGRAM MEETING: Program meets frequently to plan and review services for each client.	Program service-planning for each client 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.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.	Refer to relevant information collected to rate TMACT Items OS3 and OS4
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians 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.	Refer to Team Survey Item #5 or TMACT Item CT2. NOTE: We recommend that "time," per the DACTS protocol, be interpreted as expected billable hours for general staff, which is typically 20 hours per week. Thus, to rate a "5" on the DACTS, team leaders are ideally spending at least 10 hours per week providing direct services.

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
H5	CONTINUITY OF STAFFING: program maintains 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.	Refer to Team Survey Item #2 and use formula in DACTS Protocol for this item.
H6	STAFF CAPACITY: Program operates at full staffing.	Program has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	80-94%	Program has operated at 95% or more of full staffing in past 12 months.	Refer to Team Survey Item #3 and use formula in DACTS Protocol for this item.
H7	PSYCHIATRIST ON STAFF: there is at least one full-time psychiatrist per 100 clients assigned to work with the program.	Program for 100 clients has less than .10 FTE regular psychiatrist.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	.70-.99 FTE per 100 clients.	At least one full-time psychiatrist is assigned directly to a 100-client program.	Refer to Team Survey Items #1 and #7; or TMACT Item CT3
H8	NURSE ON STAFF: there are at least two full-time nurses assigned to work with a 100-client program.	Program for 100 clients has less than .20 FTE regular nurse.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client program.	Refer to Team Survey Items #1 and #7; or TMACT Item CT6
H9	CO-OCCURRING DISORDERS SPECIALIST ON STAFF: a 100-client program includes at least two staff members with 1 year of training or clinical experience in co-occurring disorders treatment.	Program has less than .20 FTE S/A expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year S/A training or supervised S/A experience.	Refer to Team Survey Item #1 or TMACT Item ST1; Use formula in DACTS Protocol for this item.

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
H10	EMPLOYMENT SPECIALIST ON STAFF: the program includes at least two staff members with 1 year training/ experience in employment and educational services and support.	Program has less than .20 FTE employment and education services expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.	Refer to Team Survey Item #1; or TMACT Item ST4; Use formula in DACTS Protocol for this item
H11	PROGRAM SIZE: program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.	Program has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	7.5 - 9.9	Program has at least 10 FTE staff.	Refer to Team Survey Items #1 and #7; or TMACT Item OS5
ORGANIZATIONAL BOUNDARIES							
O1	EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined mission but the admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most referrals.	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	The program actively recruits a defined population and all cases comply with explicit admission criteria.	Extrapolate from data collected to rate TMACT items OS6 and OS7

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
O2	INTAKE RATE: Program takes clients in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 clients/month.	13 -15	10 - 12	7 - 9	Highest monthly intake rate in the last 6 months no greater than 6 clients/month.	Refer to Team Survey Item #11; or TMACT Item OS8
O3	FULL RESPONSIBILITY FOR TREATMENT SERVICES: in addition to case management, program directly provides psychiatric services, counseling / psychotherapy, housing support, integrated treatment for co-occurring disorders, employment/rehabilitative services.	Program provides no more than case management services.	Program provides one of five additional services and refers externally for others.	Program provides two of five additional services and refers externally for others.	Program provides three or four of five additional services and refers externally for others.	Program provides all five of these services to clients.	Extrapolate from data collected to rate TMACT Items CP7 (psychiatric services), EP7 (counseling/psychotherapy), EP8 (housing support), and EP1 (integrated treatment for co-occurring disorders). ***Note that more stringent criteria are used to rate these TMACT items; DACTS ratings should be approximations given DACTS protocol (e.g., the DACTS does not specify 'supportive housing' or EBP-driven psychotherapy).
O4	RESPONSIBILITY FOR CRISIS SERVICES: program has 24-hour responsibility for covering psychiatric crises.	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program clients.	Program is available by telephone, predominantly in consulting role.	Program provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement.	Program provides 24-hour coverage.	Refer to TMACT Item #CP6
O5	RESPONSIBILITY FOR HOSPITAL ADMISSIONS: program is involved in hospital admissions.	Program has involvement 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.	Refer to Team Survey Item #14 and TMACT Item OS11

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
O6	RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: program is involved in planning for hospital discharges.	Program has involvement in fewer than 5% of hospital discharges.	5% - 34% of program client discharges are planned jointly with the program.	35 - 64% of program client discharges are planned jointly with the program.	65 - 94% of program client discharges are planned jointly with the program.	95% or more discharges are planned jointly with the program.	Refer to Team Survey Item #14 and TMACT Item OS11
O7	TIME-UNLIMITED SERVICES (GRADUATION RATE): Program rarely closes cases but remains the point of contact for all clients as needed.	More than 90% of clients are expected to be discharged within 1 year.	From 38-90% of clients are expected to be discharged within 1 year.	From 18-37% of clients are expected to be discharged within 1 year.	From 5-17% of clients are expected to be discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.	Refer to Team Survey Item #12 (# who transitioned to less intensive services); or TMACT Item OS9
NATURE OF SERVICES							
S1	COMMUNITY-BASED SERVICES: program works to monitor status, develop community living skills in the community rather than the 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	Refer to TMACT Item CP1
S2	NO DROPOUT POLICY: program retains a high percentage of its clients	Less than 50% of the caseload is retained over a 12-month period.	50- 64%.	65 - 79%.	80 - 94%.	95% or more of caseload is retained over a 12-month period.	Refer to Team Survey Item #12 and/or TMACT Item OS10

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
S3	ASSERTIVE ENGAGEMENT MECHANISMS: as part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., probation/parole, OP commitment) as indicated and as available.	Program passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients.	Program attempts outreach and uses legal mechanisms only as convenient.	Program usually has plan for engagement and uses most of the mechanisms that are available.	Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.	Extrapolate from TMACT Item CP2
S4	INTENSITY OF SERVICE: high total amount of service time as needed.	Average of less than 15 min/week or less of face-to-face contact per client.	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 client.	Refer to TMACT Item CP3
S5	FREQUENCY OF CONTACT: high number of service contacts as needed.	Average of less than 1 face-to-face contact / week or fewer per client.	1 - 2 / week.	2 - 3 / week.	3 - 4 / week.	Average of 4 or more face-to-face contacts / week per client.	Refer to TMACT Item CP4
S6	WORK WITH INFORMAL SUPPORT SYSTEM: with or without client present, program provides support and skills for client's support network: family, landlords, employers.	Less than .5 contact per month per client with support system.	.5-1 contact per month per client with support system in the community.	1-2 contact per month per client with support system in the community.	2-3 contacts per months per client with support system in the community.	Four or more contacts per month per client with support system in the community.	Refer to Excel Spreadsheet, Column T, where frequency of contacts is recorded for the purpose of DACTS calculation.

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
S7	INDIVIDUALIZED TREATMENT FOR CO-OCCURRING DISORDERS: one or more members of the program provide direct treatment and co-occurring disorders treatment for clients with co-occurring disorders.	No direct, individualized co-occurring disorders treatment is provided by the team.	The team variably addresses co-occurring disorders concerns with clients; no formal, individualized co-occurring disorders treatment provided.	While the team integrates some co-occurring disorders treatment into regular client contact, they provide no formal, individualized co-occurring disorders treatment.	Some formal individualized co-occurring disorders treatment is offered; clients with co-occurring disorders spend less than 24 minutes/week in such treatment.	Clients with co-occurring disorders spend, on average, 24 minutes / week or more in formal co-occurring disorders treatment.	Refer to Excel Spreadsheet, Column C. The directions specify to note whether clients receive individual therapy at least 20 minutes each week. To calculate average, according to DACTS protocol, we suggest assuming an average of 30 minute a week therapy sessions for those noted as receiving individual therapy (marked "individual" or "both"). Formula: (#clients receiving individual therapy X 30/total # of co-occurring disorder clients) = average weekly minutes.
S8	INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS TREATMENT GROUPS: program uses group modalities as a treatment strategy for people with co-occurring disorders.	Fewer than 5% of the clients with co-occurring disorders attend at least one co-occurring disorders treatment group meeting during a month.	5 - 19%	20 - 34%	35 - 49%	50% or more of the clients with co-occurring disorders attend at least one co-occurring disorders treatment group meeting during a month.	Refer to Excel Spreadsheet, Column C. Count all clients noted as receiving "group" or "both" and divide by the total number of clients noted as having a co-occurring disorder (Column A)

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
S9	INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and co-occurring disorders, and has gradual expectations of abstinence.	Program fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Program uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for persuasion of clients in denial or who don't fit AA.	Program uses mixed model: e.g., integrated treatment for co-occurring disorders principles in treatment plans; refers clients to persuasion groups; uses hospitalization for rehab; refers to AA, NA.	Program uses primarily integrated treatment for co-occurring disorders: e.g., integrated treatment for co-occurring disorders principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some s/a treatment.	Program fully based in integrated treatment for co-occurring disorders principles, with treatment provided by program staff.	Refer to data collected to rate TMACT Item EP4
S10	ROLE OF CLIENTS ON TREATMENT TEAM: Clients are involved as members of the team providing direct services.	Clients have no involvement in service provision in relation to the program.	Client(s) fill client-specific service roles with respect to program (e.g., self-help).	Client(s) work part-time in case-management roles with reduced responsibilities.	Client(s) work full-time in case management roles with reduced responsibilities.	Client(s) are employed full-time as clinicians (e.g., case managers) with full professional status.	Refer to data collected to rate TMACT Items ST7 and ST8

Program _____ Reviewer_____ Date_____

Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale

Version 1.0
Revision 3

February 28, 2018

NOTE: *This document represents only a summary of the TMACT items, definitions, and anchored ratings. A TMACT fidelity evaluation should not be completed without using the TMACT Protocol (Parts I and II) and Appendices.*

Monroe-DeVita, M., Moser, L.L. & Teague, G.B. (2013). *The tool for measurement of assertive community treatment (TMACT).* In M. P. McGovern, G. J. McHugo, R. E. Drake, G. R. Bond, & M. R. Merrens. (Eds.), *Implementing evidence-based practices in behavioral health* . Center City, MN: Hazelden.

For questions regarding the TMACT, including training and consultation in administering this fidelity measure, contact:
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ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Operations and Structure (OS) Subscale						
OS1	LOW RATIO OF CLIENTS TO STAFF: The team maintains a low client-to-staff ratio, not to exceed 10:1, which includes all direct service staff except for the psychiatric care provider. The staff count does NOT include other administrative staff such as the program assistant or other managers assigned to provide administrative oversight to the team.	26 clients per team member or more.	19 – 25	14 – 18	11 – 13	10 clients per team member or fewer.
OS2	TEAM APPROACH: ACT staff work as a transdisciplinary team rather than as independent team members; ACT staff know and work with all clients rather than carry individual caseloads. Although the entire team shares responsibility for each client, each team member contributes expertise as determined by client goals and needs identified in the person-centered plan, and carried out by each individual treatment team [ITT]).	Fewer than 25% of clients have face- to-face contacts with at least 3 team members in 4 weeks.	25 – 52%	53 - 74%	75 - 89%	90% or more clients have face- to-face contact with at least 3 team members in 4 weeks.
OS3	DAILY TEAM MEETING (FREQUENCY & ATTENDANCE): The team meets daily to review and plan services. To this end, most team members should be present to effectively carry out such a review. To constitute a daily team meeting, it must meet the following criteria: there is a review of each client's status; there is planning for future services; most team members are present.	Team meets fewer than 2 days a week.	Team meets 2 days a week.	Team meets 3 days a week with or without full attendance OR team meets 4 days a week, but without full attendance.	Team meets 4 days a week with full attendance OR team meets 5 days a week, but without full attendance.	Team meets 5 days a week with full attendance.
OS4	DAILY TEAM MEETING (QUALITY): The team uses its daily team meeting to: (1) Conduct a brief, but clinically-relevant review of all clients & contacts in the past 24 hours AND (2) Record the status of all clients. The team develops a daily staff schedule for the day's contacts based on: (3) Weekly/monthly client schedules, (4) Emerging needs, (5) Need for proactive contacts to prevent future crises; (6) Staff are held accountable for follow-through.	The daily team meeting serves no more than 3 functions.	4 functions are performed at least PARTIALLY (2 are absent).	5 functions are performed at least PARTIALLY (1 is absent) OR ALL 6 functions are performed with 4 or more PARTIALLY performed.	ALL 6 functions are performed, with up to 3 PARTIALLY performed.	ALL 6 daily team meeting functions are FULLY performed.
OS5	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	100-Client Team: 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	50-Client Team: Includes at least 7.0 FTE direct clinical staff.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Operations and Structure (OS) Subscale (cont.)						
OS6	PRIORITY SERVICE POPULATION: ACT teams serve a specific, high service-need population of adults with serious mental illness and are able to make decisions about who is served by the team. (1) The team has specific admission criteria, inclusive of schizophrenia & other psychotic disorders or bipolar I disorder, significant functional impairments, and continuous high service needs, and exclusive of a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury or personality disorders. (2) The team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.	The team at least PARTIALLY meets criterion #2 only OR does not meet either criterion.	The team PARTIALLY meets criterion #1 only.	The team PARTIALLY meets criterion #1, and at least PARTIALLY meets criterion #2.	Team FULLY meets criterion #1, and PARTIALLY meets criterion #2.	Team FULLY meets both criteria.
OS7	ACTIVE RECRUITMENT: (1) The team (or its organizational representative) actively recruits new clients who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team. (2) The team is primarily comprised of clients from referral sources and sites outside of usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach). (3) The team works to fill open slots when they are not at full capacity and/or the client-to-staff ratio is well below 10:1 on more mature teams.	The team PARTIALLY meets 1 criterion or less.	1 criterion is FULLY met (2 are absent) OR 2 criteria met, with both criteria PARTIALLY met OR 1 criterion is PARTIALLY met and 1 FULLY met (1 is absent).	2 criteria are FULLY met (1 is absent) OR ALL 3 criteria are met, with 2 or 3 PARTIALLY met.	ALL 3 criteria are met, with 2 FULLY and 1 PARTIALLY met.	ALL 3 criteria FULLY met.
OS8	GRADUAL ADMISSION RATE: The team admits new clients at a low rate to maintain a stable service environment.	Highest monthly admission rate in the last 6 months is greater than 15 clients per month.	12 -15	8 - 11	5 - 7	Highest monthly admission rate in the last 6 months no greater than 4 clients per month.
OS9	TRANSITION TO LESS INTENSIVE SERVICES: (1) The team conducts a regular assessment of the need for ACT services; (2) The team uses explicit criteria or markers to assesses 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.	Up to 1 criterion is met OR 2 criteria are met, with 1 or 2 PARTIALLY met.	2 criteria are FULLY met (3 are absent) OR 3 criteria are met, with 1 to 3 PARTIALLY (2 are absent).	3 criteria are FULLY met (2 are absent) OR 4 criteria are met, at least PARTIALLY (1 is absent).	4 criteria are FULLY met (1 is absent or only partially met).	ALL 5 criteria FULLY met.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Operations and Structure (OS) Subscale (cont.)						
OS10	RETENTION RATE: The team retains a high percentage of clients given that they enroll clients appropriate for ACT, utilize appropriate engagement techniques, and deliver individualized services. Referral to a more restrictive setting/program would normally be considered an adverse outcome.	Less than 65% of the caseload is retained over a 12-month period.	65 - 76%	77 – 86%	87 - 94%	95% or more of caseload is retained over a 12-month period.
OS11	INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating a crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the client during their hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning).	The team is involved in fewer than 15% of admissions & discharges.	The team is involved in 15% - 44% of admissions & discharges.	The team is involved in 45 - 69% of admissions & discharges.	The team is involved in 70% - 89% of admissions & discharges.	The team is involved in 90% or more admissions & discharges.
OS12	DEDICATED OFFICE-BASED PROGRAM ASSISTANCE: The team has 1.0 FTE of office-based program assistance available to facilitate the day's operations in a supportive manner for the team, clients, natural supports, and other ancillary service providers (e.g., landlords, social security). Primary functions include the following: (1) Providing direct support to staff, including monitoring & coordinating daily team schedules and supporting staff both in the office and field; (2) Serving as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports; and (3) Actively participating in the daily team meeting.	Less than 0.50 FTE program assistance is available to the team OR 0.50 - 1.0 FTE program assistance is available, but not meeting rating “2” performance.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing 2 functions OR 1.0 FTE program assistance is available and performing 1 function ONLY.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing ALL functions OR 1.0 FTE program assistance is available, at least PARTIALLY performing 2 functions.	1.0 FTE program assistance is available, at least PARTIALLY performing ALL functions.	1.0 FTE program assistance is available, FULLY performing ALL functions.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Team (CT) Subscale						
CT1	TEAM LEADER ON TEAM: The team has 1.0 full-time (i.e., works 40 hours a week) team leader with full clinical, administrative, and supervisory responsibility to the team. The team leader has no responsibility to any other programs during the 40-hour workweek. The team leader must have at least a master's degree in social work, psychology, psychiatric rehabilitation, or a related clinical field, a license in their respective field, and at least three years of experience in working with adults with severe mental illness. Team leader cannot fill more than one role on the team.	Less than 0.25 FTE team leader OR less than 0.75 FTE team leader with inadequate qualifications.	0.25 - 0.74 FTE team leader who meets at least minimal qualifications.	0.75 - 1.0 FTE team leader who does not meet minimal qualifications for education and experience.	0.75 – 0.99 FTE team leader who meets at least minimal qualifications OR 1.0 full-time team leader who meets all qualifications except having a clinical license.	1.0 FTE team leader who meets at least minimal qualifications, including licensure, and has full assigned responsibility to the team.
CT3	PSYCHIATRIC CARE PROVIDER ON TEAM: The team has at least 0.80 FTE psychiatric care provider time to directly work with a 100-client team. Minimal qualifications include the following: (1) Licensed by state law to prescribe medications; and (2) Board certified or eligible (i.e., completed psychiatric residency) in psychiatry/mental health by a national certifying body recognized and approved by the state licensing entity. For physician extenders, must have received at least one year of supervised training (pre- or post-degree) in working with people with serious mental illness.	Less than 0.20 FTE psychiatric care provider(s) per 100 clients.	0.20- 0.39 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients OR criteria for a “3” rating met, except communication standard if two or more providers, OR at least 0.20 FTE with inadequate qualifications cited.	0.40- 0.59 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients with demonstrated communication and collaboration if two providers. OR criteria for a “4” rating met, except communication standard if two or more providers.	0.60- 0.79 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients with demonstrated communication and collaboration if multiple providers. OR criteria for a “5” rating met, except communication standard if two or more providers.	At least 0.80 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients. Two or more providers must demonstrate a mechanism for adequate communication & collaboration between/among providers.
CT4	ROLE OF PSYCHIATRIC CARE PROVIDER IN TREATMENT: In addition to providing psychopharmacologic treatment, the psychiatric care provider performs the following functions in treatment: (1) Typically provides at least monthly assessment and treatment of clients’ symptoms and response to the medications, including side effects; (2) Provides brief therapy; (3) Provides diagnostic and medication education to clients, with medication decisions based in a shared decision- making paradigm; (4) Monitors clients’ non-psychiatric medical conditions and non-psychiatric medications; (5) If clients are hospitalized, communicates directly with clients’ inpatient psychiatric care provider to ensure continuity of care; and (6) Conducts home and community visits.	The psychiatric care provider performs 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (1 is absent) OR ALL 6 functions are performed, but more than 2 are PARTIALLY performed.	ALL 6 functions are performed, but up to 2 functions are only PARTIALLY performed.	ALL 6 treatment functions FULLY performed.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Team (CT) Subscale (cont.)						
CT5	ROLE OF PSYCHIATRIC CARE PROVIDER WITHIN TEAM: The psychiatric care provider performs the following functions within the team: (1) Collaborates with the team leader in sharing overall clinical responsibility for monitoring client treatment and team member service delivery; (2) Educates non-medical staff on psychiatric and non-psychiatric medications, their side effects, and health-related conditions; (3) Attends the majority of treatment planning meetings; (4) Attends daily team meetings in proportion to the minimum time expected for caseload size; (5) Actively collaborates with nurses; and (6) Provides psychiatric back-up to the program after-hours and weekends (Note: may be on a rotating basis as long as other psychiatric care providers who share on-call have access to clients' current status and medical records/current medications).	The psychiatric care provider performs no more than 2 team functions total.	3 team functions are performed.	4 team functions are performed.	5 team functions are performed.	ALL 6 team functions are performed.
CT6	NURSES ON TEAM: The team has at least 2.85 FTE registered nurses (RNs) assigned to work within a 100-client team. At least one full-time RN on the team has a minimum of one year of experience working with adults with severe mental illness. NOTE: This item is rated based on 2.85 FTE (vs. 3.0 FTE) since there is more likelihood for the team to get penalized on this item if the census goes even slightly above the 100-client team.	Less than 0.50 FTE RNs per 100 clients.	0.50 - 1.40 FTE RNs per 100 clients.	1.41 - 2.10 FTE RNs per 100 clients OR Criteria for "4" or "5" rating met, however no full-time RNs have a minimum of 1 year experience working with adults with severe mental illness.	2.11 - 2.84 FTE RNs per 100 clients.	At least 2.85 FTE Registered Nurses (RNs) per 100-client team; at least 1 full-time nurse must have at least 1 year experience working with adults with SMI. If not, rate no higher than a "3".
CT7	ROLE OF NURSES:The team nurses perform the following critical roles (in collaboration with the psychiatric care provider): (1) Manage the medication system, administer and document medication treatment; (2) Screen and monitor clients for medical problems/side effects; (3) Communicate and coordinate services with the other medical providers; (4) Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change); (5) Educate other team members to help them monitor psychiatric symptoms and medication side effects; and (6) When clients are in agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).	Nurses perform 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (1 is absent) OR ALL 6 functions are performed, but more than 3 are PARTIALLY performed.	ALL 6 functions, with up to 3 functions are PARTIALLY performed.	ALL 6 functions are FULLY performed.
Specialist Team (ST) Subscale						
ST1	CO-OCCURRING DISORDERS SPECIALIST ON TEAM: The team has at least one 1.0 FTE team member designated as a co-occurring disorders (COD) specialist who has at least a bachelor's degree and meets local standards for certification as a co-occurring specialist. Preferably this specialist has training or experience in integrated treatment for COD.	Less than 0.25 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE COD specialist with at least minimal qualifications.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Specialist Team (ST) Subscale (cont.)						
ST2	ROLE OF CO-OCCURRING DISORDERS SPECIALIST IN TREATMENT: The co-occurring disorders (COD) specialist provides integrated treatment for COD to ACT clients who have a substance use problem. Core services include the following: (1) Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health; (2) Assessing and tracking clients' stages of change readiness and stages of treatment; (3) Using outreach and motivational interviewing (MI) techniques; (4) Using cognitive behavioral approaches and relapse prevention; and (5) Applying treatment approaches consistent with clients' stage of change readiness.	The COD specialist provides 1 or fewer integrated treatment for co- occurring disorder services.	2 integrated treatment for COD services are provided (3 are absent).	3-4 integrated treatment for COD services are provided, (1 or 2 are absent) OR ALL 5 services are provided, with 3 or more services PARTIALLY provided.	ALL 5 integrated treatment for COD services are provided, but up to 2 services are only PARTIALLY provided.	ALL 5 integrated treatment for COD services are FULLY provided.
ST3	ROLE OF CO-OCCURRING DISORDERS SPECIALIST WITHIN TEAM:The co-occurring disorders (COD) specialist is a key team member in the service planning for clients with COD. The COD specialist performs the following functions WITHIN THE TEAM: (1) Modeling skills and consultation; (2) Cross-training to other staff on the team to help them develop co-occurring disorder assessment and treatment skills; (3) Attending all daily team meetings; and (4) Attending the majority of treatment planning meetings for clients with COD.	The COD specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.
ST4	EMPLOYMENT SPECIALIST ON TEAM: The team has at least 1.0 FTE team member designated as an employment specialist, with at least one year of experience providing employment services (e.g., job development, job coaching, supported employment). Ideally, the ACT employment specialist is a part of a larger supported employment & education (SEE) program within the agency.	Less than 0.25 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE employment specialist with at least minimal qualifications.
ST5	ROLE OF EMPLOYMENT SPECIALIST IN SERVICES: The employment specialist provides supported employment & education services. Core services include the following: (1) Engagement; (2) Vocational assessment; (3) Job development; (4) Job placement (including going back to school, classes); (5) Job coaching & follow-along supports (including supports in academic settings); and (6) Benefits counseling.	The employment specialist provides 2 or fewer employment services.	3 employment services are provided (3 are absent) OR 4 services are PARTALLY provided (2 are absent).	4 employment services are provided (2 are absent), but up to 3 services are only PARTIALLY provided OR 5 employment services are provided (1 is absent) OR ALL 6 services are provided, with 4 or more PARTIALLY provided.	ALL 6 employment services are provided, but up to 3 services are only PARTIALLY provided.	ALL 6 employment services are FULLY provided.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Specialist Team (ST) Subscale (cont.)						
ST6	ROLE OF EMPLOYMENT SPECIALIST WITHIN TEAM: The employment specialist is a key team member in the service planning for clients who want to work or are currently working. The employment specialist performs the following functions WITHIN THE TEAM: (1) Modeling skills and consultation; (2) Cross-training to other staff on the team to help them to develop supported employment & education approaches with clients in the team; (3) Attending all daily team meetings; and (4) Attending all treatment planning meetings for clients with employment goals.	The employment specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.
ST7	PEER SPECIALIST ON TEAM: The team has at least 1.0 FTE team member designated as a peer specialist who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following: (1) Self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) Is in the process of their own recovery; and (3) Has successfully completed training in wellness management and recovery (WMR) interventions.	Less than 0.25 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE peer specialist with at least minimal qualifications.
ST8	ROLE OF PEER SPECIALIST: The peer specialist performs the following functions: (1) Coaching and consultation to clients to promote recovery and self-direction (e.g., preparation for role in treatment planning meetings); (2) Facilitating wellness management and recovery strategies (e.g., Wellness Recovery Action Plans (WRAP), Illness Management and Recovery (IMR), or other deliberate wellness strategies); (3) Participating in all team activities (e.g., treatment planning, chart notes) equivalent to fellow team members; (4) Modeling skills for and providing consultation to fellow team members; and (5) Providing cross-training to other team members in recovery principles and strategies.	The peer specialist performs 1 or fewer functions on the team.	2 functions are FULLY performed (3 are absent) OR 2 to 3 functions performed, 1 to 2 PARTIALLY.	3 functions are FULLY performed (2 are absent or PARTIAL) OR 4 to 5 functions PARTIALLY.	4 functions are FULLY performed (1 is absent or PARTIAL).	ALL 5 functions are FULLY performed.
Core Practices (CP) Subscale						
CP1	COMMUNITY-BASED SERVICES: The team works to monitor status and develop skills in the community, rather than in-office. The team is oriented to bringing services to the client, who, for various reasons, has not effectively been served by office-based treatment.	Less than 40% of face-to-face contacts in community.	40 - 54%	55 - 64%	65 - 74%	At least 75% of total face-to-face contacts in community.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Practices (CP) Subscale (cont.)						
CP2	ASSERTIVE ENGAGEMENT MECHANISMS: The team uses an array of techniques to engage difficult-to-treat clients. These techniques include the following: (1) Collaborative, motivational interventions to engage clients and build intrinsic motivation for receiving services from the team, and, where necessary; and (2) Therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to client or others. When therapeutic limit-setting interventions are used, there is a focus on instilling autonomy as quickly as possible. In addition to being proficient in a range of engagement interventions, (3) the team has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of chosen techniques, and modifying approach when indicated.	Very little assertive engagement is evident (#1 and #2 are largely absent).	Team primarily relies on #1 OR #2, not both (1 approach is FULLY or PARTIALLY used and 1 is not used at all (No Credit).	A more limited array of assertive engagement strategies is used (PARTIAL #1 and #2).	Team uses #1 and #2 (at least 1 approach is FULLY used). Thoughtful application/ withdrawal of engagement strategies may be present or absent.	Team is proficient in assertive engagement strategies, including thoughtful application/ withdrawal of engagement strategies, applying all 3 practices.
CP3	INTENSITY OF SERVICE: The team delivers a 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 client.	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 client.
CP4	FREQUENCY OF CONTACT: The team delivers a high number of face-to-face service contacts, as needed.	Average of less than 0.5 face-to- face contact / week or fewer per client.	0.6 - 1.3 / week.	1.4 - 2.1 / week.	2.2 - 2.9 / week.	Average of 3 or more face-to-face contacts / week per client.
CP5	FREQUENCY OF CONTACT WITH NATURAL SUPPORTS: The team has access to clients' natural supports. These supports either already existed, and/or resulted from the team's efforts to help clients develop natural supports. Natural supports include people in the client's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy).	For less than 25% of clients, the natural support system is contacted by team at least 1 time per month.	26% - 50%	51% - 75%	76% - 89%	For at least 90% of clients, the natural support system is contacted by team at least 1 time per month.
CP6	RESPONSIBILITY FOR CRISIS SERVICES: The team has 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria: (1) The team is available to clients in crisis 24 hours a day, seven days a week; (2) The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging); (3) The team accesses practical, individualized crisis plans to help them address crises for each client; and (4) The team is able and willing to respond to crises in person, when needed.	Team has no responsibility for directly handling crises after-hours.	Team meets up to 2 criteria at least PARTIALLY OR criterion #1 is not met.	Team meets criterion #1 and at least PARTIALLY meets 2 to 3 criteria.	Team meets 3 criteria FULLY and 1 PARTIALLY.	Team FULLY meets all 4 criteria.

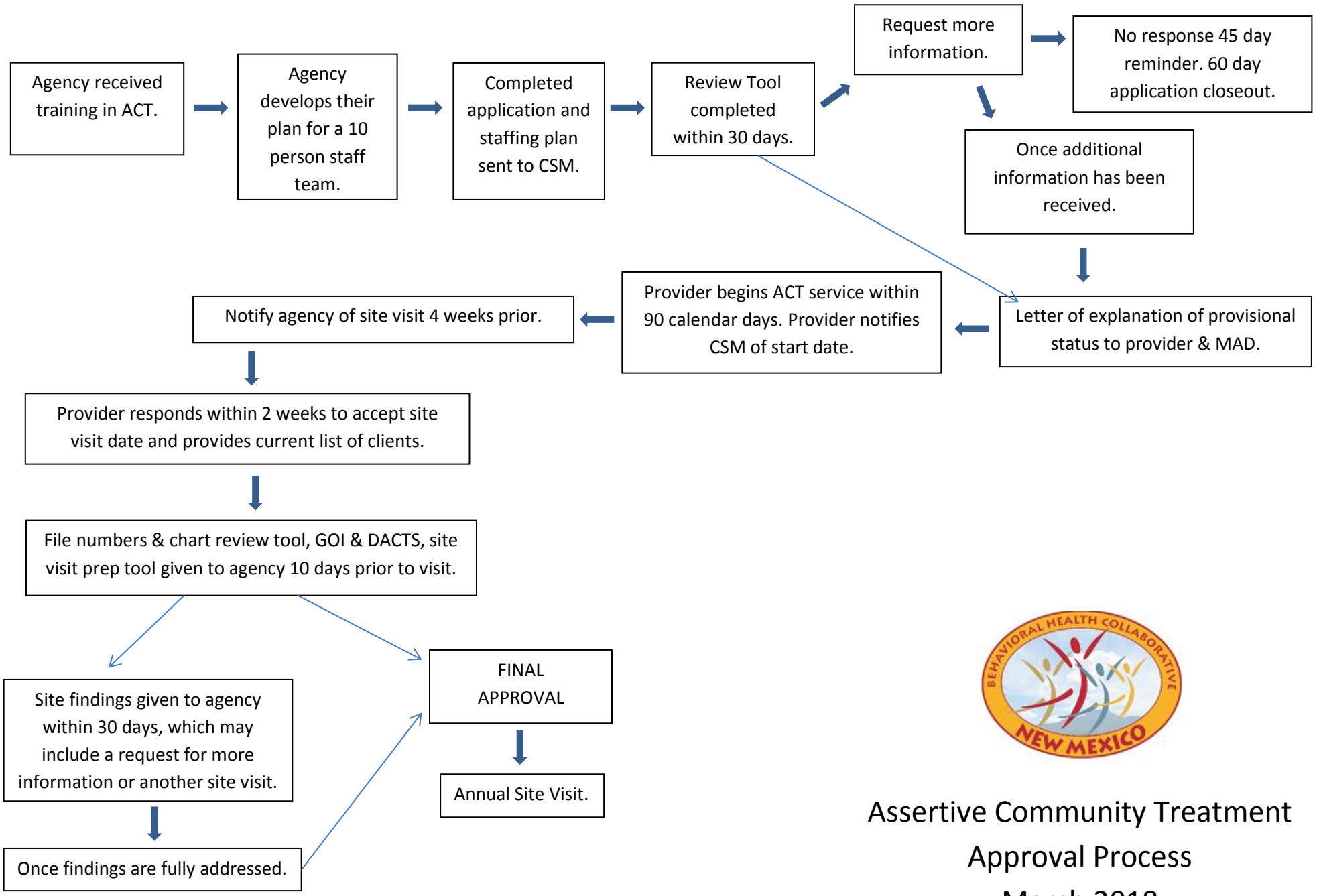
ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Practices (CP) Subscale (cont.)						
CP7	FULL RESPONSIBILITY FOR PSYCHIATRIC SERVICES: The team assumes responsibility for providing psychiatric services to clients, where there is little need for clients to have to access such services outside of the team. The psychiatric care provider assumes most of the responsibility for psychiatric services. However, the team's role in medication administration and monitoring are also considered in this assessment, especially when evaluating psychiatric services provided to clients residing in supervised settings where non-ACT staff also manage medications; the expectation is that ACT staff play an active role in monitoring medication management even when a client is in a residential setting.	Less than 20% of clients in need of psychiatric services are receiving them from the team.	20 - 49% of clients in need of psychiatric services are receiving them from the team.	50 - 74% of clients in need of psychiatric services are receiving them from the team.	75 - 89% of clients in need of psychiatric services are receiving them from the team.	90% or more of clients in need of psychiatric services are receiving them from the team.
CP8	FULL RESPONSIBILITY FOR PSYCHIATRIC REHABILITATION SERVICES: These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration). Psychiatric rehabilitation should address functional deficits, environment, as well as the lack of necessary resources, all of which are identified through the assessment process. As such, deliberate and consistent skills training which typically includes staff demonstration, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings. Psychiatric rehabilitation services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, and weekly client schedules).	Less than 20% of clients in need of psychiatric rehabilitation services are receiving them from the team.	20 - 49% of clients in need of psychiatric rehabilitation services are receiving them from the team.	50 - 74% of clients in need of psychiatric rehabilitation services are receiving them from the team.	75 - 89% of clients in need of psychiatric rehabilitation services are receiving them from the team.	90% or more of clients in need of psychiatric rehabilitation services are receiving them from the team.
Evidence-Based Practices (EP) Subscale						
EP1	FULL RESPONSIBILITY FOR INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: The team assumes responsibility for providing integrated treatment for co-occurring disorders (COD) services within the larger framework of integrated treatment for COD, where there is little need for clients to have to access such services outside of the team. Core services include systematic and integrated screening and assessment and interventions tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing) and later stages of change readiness (e.g., CBT, relapse prevention). It is expected that the ACT COD specialist will assume the majority of responsibility for delivering integrated treatment for co-occurring disorders, but ideally other team members also provide some integrated treatment for co-occurring disorders services. Integrated treatment for co- occurring disorders reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of integrated treatment for COD are receiving them from the team.	20 - 49% of clients in need of integrated treatment for COD are receiving them from the team.	50 - 74% of clients in need of integrated treatment for COD are receiving them from the team.	75 - 89% of clients in need of integrated treatment for COD are receiving them from the team.	90% or more of clients in need of integrated treatment for COD are receiving them from the team.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Evidence-Based Practices (EP) Subscale (cont.)						
EP2	FULL RESPONSIBILITY FOR EMPLOYMENT AND EDUCATIONAL SERVICES: The team assumes responsibility for providing employment and educational (EE) services to clients, where there is little need for clients to have to access such services outside of the team. Core services include engagement, vocational assessment, job development, job placement (including going back to school, classes), and job coaching & follow-along supports (including supports in academic/school settings). It is expected that the ACT Employment Specialist will assume the majority of responsibility for delivering EE services, but ideally other team members also provide some EE services. Employment and educational services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of employment and educational services are receiving them from the team.	20 - 49% of clients in need of EE services are receiving them from the team.	50 - 74% of clients in need of EE services are receiving them from the team.	75 - 89% of clients in need of EE services are receiving them from the team.	90% or more of clients in need of EE services are receiving them from the team.
EP3	FULL RESPONSIBILITY FOR WELLNESS MANAGEMENT AND RECOVERY SERVICES: The team assumes responsibility for providing wellness management and recovery (WMR) services to clients, where there is little need for clients to have to access such services outside of the team. These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. Examples of such services include the development of Wellness Recovery Action Plans (WRAP) and provision of the Illness Management and Recovery (IMR) curriculum. WMR services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of WMR services are receiving them from the team.	20 - 49% of clients in need of WMR services are receiving them from the team.	50 - 74% of clients in need of WMR services are receiving them from the team.	75 - 89% of clients in need of WMR services are receiving them from the team.	90% or more of clients in need of WMR services are receiving them from the team.
EP4	INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: The TEAM practices from a model aligning with integrated treatment for co-occurring disorders (COD) where the TEAM (1) considers interactions between mental illness and COD; (2) does not have absolute expectations of abstinence and supports harm reduction; (3) understands and applies stages of change readiness in treatment; (4) is skilled in motivational interviewing; and (5) follows cognitive-behavioral principles.	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met.	Team primarily operates from integrated treatment for COD, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team is fully based in integrated treatment for COD principles, FULLY meeting all 5 criteria.
EP5	SUPPORTED EMPLOYMENT AND EDUCATION (SEE): The TEAM practices from a model aligning with evidence-based supported employment and education (SEE) and the TEAM: (1) Values competitive work as a goal for all clients; (2) Believes and supports that a client's expressed desire to work is the only eligibility criterion for SEE services; (3) Believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment; (4) Believes and supports that placement should be individualized and tailored to a client's preferences; and (5) Believes that ongoing supports and job coaching should be provided when needed and desired by client, and has provided such supports.	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met.	Team primarily embraces SEE, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team fully embraces SEE and FULLY meets all 5 criteria.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Evidence-Based Practices (EP) Subscale (cont.)						
EP6	ENGAGEMENT & PSYCHOEDUCATION WITH NATURAL SUPPORTS: The FULL TEAM works in partnership with clients' natural supports. As part of their active engagement of natural supports, the team: (1) Provides education about their loved one's illness; (2) Teaches problem-solving strategies for difficulties caused by illness; and (3) Provides &/or connects natural supports with social & support groups.	Team does not use any of the specified strategies with clients' natural supports.	1 or 2 services are provided.	ALL 3 services are provided, but 2-3 strategies only PARTIALLY.	ALL 3 services are provided but 1 only PARTIALLY.	ALL 3 services are FULLY provided by team.
EP7	EMPIRICALLY-SUPPORTED PSYCHOTHERAPY: The team: (1) deliberately provides individual and/or group psychotherapy, as specified in the treatment plan; (2) uses empirically-supported techniques to address specific symptoms and behaviors; and (3) maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services. Although all team members can be trained to effectively use therapeutic techniques, such as cognitive behavioral therapy and motivational interviewing, the team also ideally has a licensed therapist.	Team does not provide psychotherapy to clients. No criteria are met.	1 to 2 criteria are PARTIALLY met.	Criterion #1 is PARTIALLY met and criteria #2 and #3 is at least PARTIALLY met OR Team FULLY meets both criteria #1 and #2, but does not meet criterion #3.	Team FULLY meets criterion #1, PARTIALLY meets criterion #2, and at least PARTIALLY meets criterion #3. OR Team FULLY meets both criteria #1 and #2 and only PARTIALLY meets criterion #3.	Team FULLY meets all 3 criteria.
EP8	SUPPORTIVE HOUSING: The team embraces supportive housing, including: (1) assisting clients in locating housing of their choice (e.g., providing multiple housing options, including integrated housing); (2) respect for clients' privacy within residence; (3) assistance in accessing affordable, safe/decent, and permanent housing; and (4) assured ongoing tenancy rights, regardless of clients' progress or success in ACT services.	Team meets no more than 1 criterion.	3 criteria PARTIALLY met OR 2 criteria met, at least PARTIALLY.	4 criteria met, with at least 2 PARTIALLY met OR 3 criteria met, with at least 1 criterion FULLY met.	ALL 4 criteria met, with up to 1 criterion PARTIALLY met (remaining 3 criteria are FULLY met).	ALL 4 criteria FULLY met.
Person-Centered Planning & Practices (PP) Subscale						
PP1	STRENGTHS INFORM TREATMENT PLAN: (1) The team is oriented toward clients' strengths and resources, and (2) clients' strengths and resources inform treatment plan development.	Strengths are not assessed (no criteria #1).	Team variably attends to clients' strengths and resources and strengths/ resources do not inform planning (Partial #1 only).	Team is clearly attentive to clients' strengths and resources, but clients' strengths and resources do not typically inform plan development (Full #1 and No credit #2) OR Team is variably attentive to strengths and uses this information to inform plans, but less systematically (Partial #1 and Partial #2).	Team is clearly attentive to clients' strengths and resources, which informed plan development for some (Full #1 and Partial #2).	Team is highly attentive to clients' strengths and resources, and gathers such information for the purpose of treatment planning (Full #1 and Full #2).

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Person-Centered Planning & Practices (PP) Subscale (cont.)						
PP2	PERSON-CENTERED PLANNING : The team creates treatment plans using a person-centered approach, including: (1) Development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting) and with the team, preferable the individual treatment team (ITT); (2) Conducting regularly scheduled treatment planning meetings; (3) Attendance by key staff (i.e., members of the ITT), the client, and anyone else they prefer (e.g., family), tailoring number of participants to fit with the client's preferences; (4) Provision of guidance and support to promote self-direction and leadership within the meeting, as needed; and (5) Treatment plan is clearly driven by the client's goals and preferences.	No more than 1 function of person- centered planning is performed OR 2 functions are performed, but not fully.	2 functions of person-centered planning are FULLY performed (3 are absent) OR 3 functions are performed at least PARTIALLY (3 are absent).	4 functions of person-centered planning are performed (1 absent) OR 5 functions performed, with 3 or more PARTIALLY performed.	ALL 5 functions of person-centered planning are performed, with up to 2 PARTIALLY performed.	ALL 5 functions of person-centered planning are FULLY performed.
PP3	INTERVENTIONS TARGET A BROAD RANGE OF LIFE DOMAINS: The team attends to a range of life domains (e.g., physical health, employment/education, housing satisfaction, legal problems) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in treatment plans and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs.	The team does not plan for and/or deliver interventions that reflect a breadth of life domains.	Team minimally plans for and/or delivers interventions that reflect life domains (PARTIAL credit for one criterion only) OR Team plans for but does not deliver a breadth of services (Full #1 only).	Team plans for and delivers interventions that reflect a breadth of life domains, but less systematically (PARTIAL #1 and PARTIAL #2) OR a larger breadth of services are planned for, but not in turn delivered (FULL #1 and PARTIAL #2).	Team delivers interventions that reflect a range of life domains to all clients (FULL #2), but interventions targeting a breadth of life domains are not systematically specified in treatment plans (PARTIAL #1 OR FULL #1, but lacking Alignment).	Team specifies interventions that target a range of life domains in treatment plans and these interventions are carried out in practice (FULL criteria #1 and #2 with Alignment).
PP4	CONSUMER SELF-DETERMINATION & INDEPENDENCE: The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.	None of the 3 practices are employed OR only 1 is employed (FULLY or PARTIALLY).	2 practices are employed (FULLY or PARTIALLY), with 1 absent.	3 practices are employed, with 2 to 3 PARTIALLY.	Team generally promotes clients' self-determination and independence. All 3 practices are employed, but 1 PARTIALLY employed.	Team is a strong advocate for clients' self-determination and independence. All 3 practices FULLY employed.

APPENDIX ZR



Assertive Community Treatment Approval Process

March 2018

HUMAN SERVICES DEPARTMENT

APPENDIX ZS

New Mexico Human Services Department/Behavioral Health Services Division
State Opiate Treatment Authority
Review of Policy & Procedure Manual for an Opioid Treatment Program (OTP)

Facility Name: _____ **Name of Sponsor:** _____

Sponsor e-mail: _____ **Sponsor Phone:** _____

Facility Address: _____

_____

Name of person who has ultimate authority for this agency: _____

	Requirement	Location	
	7.32.8.18 Administration		
A.	**The program sponsor shall ensure that a physician licensed to practice in New Mexico is designated to serve as medical director and to have authority over all medical aspects of opioid treatment.**		
B.	**The program sponsor shall ensure that the medical director is responsible for ensuring that the OTP is in compliance with all applicable federal, state and local laws and regulations.**		
C.	**The program sponsor shall ensure that the OTP shall be open for patients every day of the week except for federal and state holidays, and Sundays, and be closed only as allowed in advance in writing by CSAT and the state methadone authority.**		

D.	**The program sponsor shall ensure that written policies and procedures are developed, implemented, complied with and maintained at the OTP and include:**		
1.	**procedures to prevent a patient from receiving opioid dependency treatment from more than one agency or physician concurrently;**		
2.	**procedures to meet the unique needs of diverse populations, such as pregnant women, children, individuals with communicable diseases, (e.g. hepatitis C, tuberculosis, HIV or AIDS), or individuals involved in the criminal justice system;**		
3.	**procedures for conducting a physical examination, assessment and laboratory tests;**		
4.	**procedures for establishing substance abuse counselor caseloads, based on the intensity and duration of counseling required by each patient;**		
5.	**criteria for when the patient's blood serum levels should be tested and procedures for having the test performed;**		
6.	**procedures for performing laboratory tests, such as urine drug screens or toxicological tests, including procedures for collecting specimens for testing;**		
7.	**procedures for addressing and managing a patient's concurrent use of alcohol or other drugs;**		
8.	**procedures for providing take home medication to patients;**		
9.	**procedures for conducting opioid treatment withdrawal;**		
10.	**procedures for conducting an administrative withdrawal;**		
11.	**procedures for voluntary discharge, including a requirement that a patient discharged voluntarily be provided or offered follow-up services, such as counseling or a referral for medical treatment;**		
12.	**procedures for making temporary or permanent transfer of a patient from the OTP to another OTP;**		
13.	**procedures for receiving the temporary or permanent transfer of a patient from another OTP to the OTP;**		
14.	**procedures to minimize the following adverse events:** **(a) a patient's loss of ability to function;** **(b) a medication error;** **(c) harm to a patient's family member or another individual**		

	resulting from ingesting a patient's medication; **(d) sales of illegal drugs on the premises;** **(e) diversion of a patient's medication;** **(f) harassment or abuse of a patient by a staff member or another patient; and** **(g) violence on the premises;**		
15.	**procedures to respond to an adverse event, including:** **(a) a requirement that the program sponsor immediately investigate the adverse event and the surrounding circumstances;** **(b) a requirement that the program sponsor develop and implement a plan of action to prevent a similar adverse event from occurring in the future; monitor the action taken; and take additional action, as necessary, to prevent a similar adverse event;** **(c) a requirement that action taken under the plan of action be documented; and** **(d) a requirement that the documentation be maintained at the agency for at least two years after the date of the adverse event;**		
16.	**procedures for infection control;**		
17.	**criteria for determining the amount and frequency of counseling that is provided to a patient; procedures to ensure that the facility's physical appearance is clean and orderly;**		
18.	**a process for resolution of patient complaints, including a provision that complaints which cannot be resolved through the clinic's process may be referred by either party to the department of health:** **(a) the complaint process shall be explained to the patient at admission;** **(b) the patient complaint process shall be posted prominently in its waiting area or other location where it will be easily seen by patients, and include the department of health contact information for use in the event that the complaint cannot be resolved through the clinic's process.**		
E.	**a written quality assurance plan is developed and implemented;**		

F.	**all information and instructions for the patient are provided in the patient's primary language, and, when provided in writing, are clear and easily understandable by the patient.**		
7.32.8.19 ADMISSSION			
A.	**The program sponsor shall ensure through policy and procedure that an individual is only admitted for opioid dependency treatment after the program medical director determines and documents that:**		
1.	**the individual meets the definition of opioid dependence using generally accepted medical criteria such as those contained in the diagnostic and statistical manual for mental disorders (DSM-IV or subsequent editions);**		
2.	**the individual has received a physical examination as required by Subsection D of 7.32.8.19 NMAC below; and**		
3.	**if the individual is requesting maintenance treatment, the individual has been addicted for at least 12 months before the admission, unless the individual receives a waiver of this requirement from the program medical director because the individual:**		
a.	**was released from a penal institution within the last six months;**		
b.	**is pregnant, as confirmed by the agency physician;**		
c.	**was treated for opioid dependence within the last 24 months; or**		
d.	**is under the age of 18, has had two documented unsuccessful attempts at short term opioid treatment withdrawal procedures or drug-free treatment within a 12-month period, and has informed consent for treatment provided by a parent, guardian, custodian or responsible adult designated by the relevant state authority.**		
B.	**A program sponsor shall ensure that an individual requesting long-term or short-term opioid treatment withdrawal treatment who has had two or more unsuccessful opioid treatment withdrawal treatment episodes within a 12-month period is assessed by the program medical director for other forms of treatment.**		

C.	**The OTP shall ensure that each patient at the time of admission:**		
1.	**provides written, voluntary, program-specific informed consent to treatment;**		
2.	**is informed of all services that are available to the patient through the program and of all policies and procedures that impact the patient's treatment; and**		
3.	**is informed of the following:** **(a) the progression of opioid dependency treatment and the patient's apparent stage of opioid dependence;** **(b) the goal and benefits of opioid dependency treatment;** **(c) the signs and symptoms or overdose and when to seek emergency assistance;** **(d) the characteristics of opioid dependency treatment medication, such as its effects and common side effects, the dangers of exceeding the prescribed dose, and potential interaction effects with other drugs, such as other non-opioid agonist treatment medications, prescription medications, and illicit drugs;** **(e) the requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law;** **(f) the requirement for a staff member to comply with the confidentiality requirements of title 42 CFR part 2 of the code of federal regulations, incorporated by reference;** **(g) drug screening and toxicological testing procedures;** **(h) requirements to receive take home medication;** **(i) testing and treatment available for HIV and other communicable diseases, the availability of immunization for hepatitis A and B, and the availability of harm reduction services;** **(j) availability of counseling on preventing exposure to and transmission of human immunodeficiency virus (HIV), sexually transmitted diseases, and blood-born pathogens;** **(k) the patient's right to file a complaint with the program for any reason, including involuntary discharge, and to have the patient's complaint handled in a fair and timely manner.**		

D.	**A program sponsor shall ensure that the program medical director or medical practitioner designee conducts a complete, fully documented physical examination of an individual who requests admission to the program before the individual receives a dose of opioid dependency treatment medication, and that the physical examination includes:**		
1.	**reviewing the individual's bodily systems;**		
2.	**obtaining a medical and family history and documentation of current information to determine chronic or acute medical conditions such as diabetes, renal diseases, hepatitis, HIV infection, tuberculosis, sexually transmitted disease, pregnancy or cardiovascular disease;**		
3.	**obtaining a history of behavioral health issues and treatment, including any diagnoses and medications;**		
4.	**initiating the following laboratory tests:** **(a) a mantoux skin test;** **(b) a test for syphilis;** **(c) a laboratory drug detection test for at least opioids, methadone, amphetamines, cocaine, barbiturates, benzodiazepines and other substances as may be appropriate, based upon patient history and prevailing patterns of availability and use in the local area;**		
5.	**recommending additional tests based upon the individual's history and physical condition, such as: (a) complete blood count;** **(b) EKG, chest X-ray, pap smear or screening for sickle cell disease;** **(c) a test for hepatitis B and C; or** **(d) HIV testing.**		
6.	**the full medical examination including test results must be completed within 14 days of admission to the program;**		
7.	**a patient re-admitted within three months after discharge does not require a repeat physical examination unless requested by the program medical director.**		
E.	**A program sponsor shall ensure that the results of a patient's physical examination are documented in the patient record.**		

F.	**A patient may not be enrolled in more than one OTP program except under exceptional circumstances, such as residence in one city and employment that requires extended absences from that city, which must be documented in the patient chart by the medical directors of both programs:**		
1.	**an OTP shall make and document good faith efforts to determine that a patient seeking admission is not receiving opioid dependency treatment medication from any other source, within the bounds of all applicable patient confidentiality laws and regulations;**		
2.	**the OTP shall confirm that the patient is not receiving treatment from any other OTP, except as provided in Subsection F of 7.32.8.19 NMAC, within a 50 mile radius of its location, by contacting any such other program, or by using the central registry described in Subsection G of 7.32.8.19 NMAC, when established.**		
G.	**The department of health may establish an internet-based central registry of all persons in New Mexico who are current patients of a New Mexico OTP program, for the purpose of creating a system that prevents patients from surreptitiously receiving medication from more than one OTP. Each OTP as a condition of approval to operate shall participate in the central registry as directed by the department of health.**		
7.32.8.20 ASESSMENT AND TREATMENT PLANS			
	The program sponsor shall ensure that:		
A.	**each patient receives a comprehensive intake assessment upon admission, conducted by a qualified professional, to determine the most appropriate combination of services and treatment, which results in an intake treatment plan based on the patient's goals; the results of the comprehensive intake assessment and the intake treatment plan are documented in the patient record within 24 hours of admission;**		
B.	**an individualized treatment plan shall replace the intake treatment plan within 30 days of admission or the third face-to-face contact with the client, and be documented in the patient record;**		
C.	**all updates or revisions to any treatment plan or assessment shall be documented in the patient record within 7 working days;**		

D.	**all assessments and/or treatment plans shall include, but not necessarily be limited to:**		
1.	**a description of the patient's presenting issue, identification of the patient's behavioral health symptoms and the behavioral health issue or issues that require treatment;**		
2.	**a list of the medical services, including medication, needed by the patient, as identified in the physical examination;**		
3.	**recommendations for further assessment or examination of the patient's needs if indicated;**		
4.	**recommendations for treatment needed by the patient, such as psychosocial counseling or mental health treatment, if indicated;**		
5.	**recommendations for ancillary services or other services needed by the patient, if indicated;**		
6.	**the signature, professional credential, printed name, and date signed of the staff member conducting and developing the assessment, treatment plan, update or revision;**		
7.	**in the case of updated or revised treatment plans, a summary of the patient's progress or lack of progress toward each goal on the previous plan and the program's response; and any new goals;**		
8.	**the signature and date signed, or documentation of the refusal to sign, of the patient or the patient's guardian or agent or, if the patient is a child, the patient's parent, guardian, or custodian;**		
E.	**treatment plans shall be reviewed at least every 90 days for the first 2 years of continuous treatment, and at least every 6 months thereafter, in accordance with the program's established policy and procedure, and the treatment plan modified accordingly, except initial treatment plans must be replaced with individualized plans as provided for in Subsection B of 7.32.8.20 NMAC above;**		
F.	**adequate medical, psychosocial counseling, mental health, vocational, educational and other assessment and treatment services are fully and reasonably available to patients, either by the program directly, or through formal, documented referral agreements with other providers.**		

7.32.8.21 DOSAGE			
	The program sponsor shall ensure that:		
A.	**a dose of opioid dependency treatment medication is administered only after an order from the program medical director;**		
B.	**a patient's dosage of opioid dependency treatment medication is individually determined;**		
C.	**a dose of opioid dependency treatment medication is sufficient to produce the desired response in a patient for the desired duration of time and with consideration for patient safety;**		
D.	**a dose of opioid dependency medication is prescribed to meet a patient's treatment needs by:**		
1.	**preventing the onset of subjective or objective signs of withdrawal for 24 hours or more;**		
2.	**reducing or eliminating the drug craving that is experienced by opioid dependent individuals who are not in opioid treatment;**		
3.	**a patient receiving comprehensive maintenance treatment receives an initial dose of opioid dependency treatment medication based upon the program medical director or medical practitioner designee's physical examination and with consideration for local issues, such as the relative purity of available illicit opioid drugs;**		
4.	**a patient receiving methadone in comprehensive maintenance treatment receives an initial dose of methadone that does not exceed 30 milligrams; and (a) if the patient's withdrawal symptoms are not suppressed after the initial dose of 30 milligrams, a patient receives an additional dose that does not exceed 10 milligrams only if a program clinician documents in the patient record that 30 milligrams did not suppress the patient's withdrawal symptoms; and (b) if the patient's withdrawal symptoms are not suppressed by a total dose of 40 milligrams, a patient receives an additional dose only if the program medical director or medical practitioner designee documents in the patient record that 40 milligrams did not suppress the patient's withdrawal symptoms;**		
5.	**a patient receiving buprenorphine in opioid treatment withdrawal procedure or comprehensive maintenance treatment receive an initial dose according to the instructions on the opioid dependency treatment medication package insert,**		

	and any deviation from the instructions is documented by the program clinician in the patient record;		
6.	**a patient receives subsequent doses of opioid dependency treatment medication:** **(a) based on the patient's individual needs and the results of the physical examination and assessment;** **(b) sufficient to achieve the desired response for at least 24 hours, with consideration for day-to-day fluctuations and elimination patterns;** **(c) that are not used to reinforce positive behavior or punish negative behavior;** **(d) as long as the patient benefits from and desires comprehensive maintenance treatment; and** **(e) that are adjusted if a provider changes from one type of opioid dependency treatment medication to another.**		
7.32.8.22 DRUG SCREENING			
	The program sponsor shall ensure that:		
A.	**staff members have knowledge of the benefits and limitations of laboratory drug detection tests and other toxicological testing procedures;**		
B.	**a patient in comprehensive maintenance treatment receives at least eight random laboratory drug detection tests per year; short-term opioid treatment withdrawal procedure patients receive at least one initial drug abuse test; long-term opioid treatment withdrawal procedure patients receive an initial and monthly random tests; and other toxicological tests are performed according to written orders from the program medical director or medical practitioner designee;**		
C.	**laboratory drug detection tests and other toxicological testing specimens are collected in a manner that minimizes falsification;**		
D.	**laboratory drug detection tests for:** **(1) opioids;** **(2) methadone;** **(3) amphetamines;** **(4) cocaine;** **(5) barbiturates;** **(6) benzodiazepines; and** **(7) other substances as may be appropriate, based upon**		

	patient history and prevailing patterns of drug availability and use in the local area;		
E.	**the results of a patient's laboratory drug detection tests or other toxicological test and any action taken relating to the results are documented in the patient record.**		
7.32.8.23 TAKE-HOME MEDICATIONS			
A.	**The program sponsor shall ensure that policies and procedures are developed, implemented, and complied with for the use of take-home medication and include:**		
1.	**criteria for determining when a patient is ready to receive take-home medication;**		
2.	**criteria for when a patient's take-home medication is increased or decreased;**		
3.	**a requirement that take-home medication be dispensed according to federal and state law;**		
4.	**a requirement that the program medical director review a patient's take-home medication regimen at intervals of no less than 90 days and adjust the patient's dosage, as needed;**		
5.	**procedures for safe handling and secure storage of take-home medication in a patient's home; and**		
6.	**criteria and duration of allowing a physician to prescribe a split medication regimen.**		
B.	**Treatment program decisions on dispensing OTP medications to patients for unsupervised use, beyond that set forth in Subsection C of 7.32.8.23 NMAC below, shall be made by the program medical director, based on the following criteria:**		
1.	**absence of recent abuse of drugs, including alcohol;**		
2.	**regularity of program attendance;**		
3.	**length of time in comprehensive maintenance treatment;**		
4.	**absence of known criminal activity;**		
5.	**absence of serious behavioral problems at the program;**		
6.	**special needs of the patient such as physical health needs;**		
7.	**assurance that take-home medication can be safely stored in the patient's home;**		
8.	**stability of the patient's home environment and social relationships;**		
9.	**the patient's work, school, or other daily activity schedule;**		

10.	**hardship experienced by the patient in traveling to and from the program; and**		
11.	**whether the benefit the patient would receive by decreasing the frequency of program attendance outweighs the potential risk of diversion.**		
C.	**A patient in comprehensive maintenance treatment may receive a single dose of take-home medication for each day that a provider is closed for business, including Sundays and state and federal holidays.**		
D.	**A program sponsor shall ensure that take-home medication is only issued to a patient in compliance with the following restrictions:**		
1.	**during the first 90 days of comprehensive maintenance treatment, take-home medication is limited to a single dose each week, in addition to any doses received as described in Subsection C of 7.32.8.23 NMAC above;**		
2.	**during the second 90 days of comprehensive maintenance treatment, a patient may receive a maximum of two doses of take-home medication each week in addition to any doses received as described in Subsection C of 7.32.8.23 NMAC above;**		
3.	**during the third 90 days of comprehensive maintenance treatment, a patient may receive a maximum of three doses of take-home medication each week in addition to any doses received as described in Subsection C of 7.32.8.23 NMAC above;**		
4.	**in the remaining months of the patient's first year, a patient may receive a maximum of 6 days of take-home medication each week;**		
5.	**after one year of continuous treatment, a patient may receive a maximum 2-week supply of take-home medication;**		
6.	**after two years of continuous treatment, a patient may receive a maximum of one month's supply of take-home medication but must make monthly visits;**		
7.	**exceptions to the above take-home medication restrictions shall be made only as provided for in center for substance abuse treatment (CSAT) regulations and as approved by the state methadone authority.**		
E.	**A program sponsor shall ensure that a patient receiving take-home medication receives:**		
1.	**take-home medication in a child-proof container; and**		

2.	**written and verbal information on the patient's responsibilities in protecting the security of take-home medication.**		
F.	**The program sponsor shall ensure that the program medical director's determination made under Subsection B of 7.32.8.23 NMAC and the reasons for the determination are documented in the patient record.**		
G.	**In accordance with DEA regulations, the program shall not use U. S. mail or express services such as fedex or united parcel service to transport, furnish or transfer opioid treatment medication to any patient, agency, facility or person.**		
H.	**The program shall establish policy and procedure to provide for the safe and secure transportation of opioid treatment medication from its facility to another agency where the program's patient temporarily resides, (e.g., from the University of New Mexico's Addiction and Substance Abuse Program (ASAP) to the Turquoise Lodge treatment program.).**		
7.32.8.24 WITHDRAWAL TREATMENT AND MEDICALLY SUPERVISED DOSE REDUCTION			
A.	**The program sponsor shall ensure that: policies and procedures are developed, implemented, and complied with for withdrawal treatment and:**		
1.	**are designed to promote successful withdrawal treatment;**		
2.	**require that dose reduction occur at a rate deemed medically appropriate by the program medical director;**		
3.	**require that a variety of ancillary services, such as self-help groups, be available to the patient through the program or through referral;**		
4.	**require that the amount of counseling available to the patient be increased before discharge; and**		
5.	**require that a patient be re-admitted to the program or referred to another program if relapse occurs;**		
B.	**a patient's withdrawal treatment:**		
1.	**for a patient involved in comprehensive maintenance treatment, is only initiated as administrative withdrawal, or when voluntarily requested by the patient and approved by a program medical director; and**		
2.	**is planned and supervised by the program medical director;**		
C.	**before a patient begins withdrawal treatment, whether with or against the advice of the program medical director, the patient:**		

1.	**is informed by the program medical director or a medical practitioner designee:** **(a) that the patient has the right to leave opioid treatment at any time; and** **(b) of the risks of withdrawal treatment; and**		
2.	**upon request, receives a schedule for withdrawal treatment that is developed by the program medical director with input from the patient;**		
3.	**receives a copy of the program policy regarding withdrawal of opioid medication against medical advice and a verbal explanation of that policy;**		
D.	**if a patient who is receiving withdrawal treatment, other than a patient experiencing administrative withdrawal, appears to a staff member to relapse, the patient is permitted to begin comprehensive maintenance treatment, if otherwise eligible;**		
E.	**if a patient who has completed withdrawal treatment within the past 30 days appears to a staff member to relapse, the patient may be re-admitted without a physical examination or assessment with the consent of the program medical director;**		
F.	**a patient experiencing administrative withdrawal is referred or transferred to any program that is capable of or more suitable for meeting the patient's needs, and the referral or transfer is documented in the patient record;**		
G.	**the following information is documented in the patient record:**		
1.	**the reason that the patient sought withdrawal treatment or was placed on administrative withdrawal; and**		
2.	**the information and assistance provided to the patient in medical withdrawal or administrative withdrawal.**		
7.32.8.25 COUNSELING AND MEDICAL SERVICES			
A.	**The program sponsor shall ensure that:** **substance abuse counseling and behavioral health treatment planning is provided by a practitioner licensed in the state of New Mexico to provide behavioral health treatment services to each patient based upon the patient's individual needs, treatment plan and stage of readiness to change behavior;**		
B.	**the program has substance abuse counselors in a number sufficient:**		
1.	**to ensure that patients have access to counselors;**		
2.	**to provide the treatment in patients' treatment plans; and**		

3.	**to provide unscheduled treatment or counseling to patients;**		
C.	**each patient seeking opioid treatment is screened for the presence of a co-occurring mental health disorder by means approved by the department of health, and if indicated, referred for assessment and possible treatment if the program is not able to provide mental health services; an OTP referring a patient to another provider for mental health assessment shall make and document its good faith efforts to follow up with that provider on the results of the referral, and to co-ordinate its treatment with any subsequent treatment by other providers, within the limits of all applicable laws and regulations pertaining to release of patient information and confidentiality;**		
D.	**a program sponsor shall ensure that a patient is offered medical, psychiatric and psychological services, if needed, either at its program or through referral:**		
1.	**if a patient receives medical, psychiatric or psychological services, from provider(s) not affiliated with the program, program staff members shall make a good faith effort to communicate and coordinate its treatment services with such provider, including monitoring and evaluating interactions between the patient's opioid treatment medication and medications used to treat the patient's mental disorder, if any;**		
2.	**the OTP shall have a procedure to ensure that such good faith coordination efforts are made, in accordance with all state and federal laws and regulations for the release of patient records or information;**		
E.	**a program sponsor shall make good faith efforts to establish effective working relationships with the relevant behavioral health treatment providers in its patient catchment area in order to facilitate patient access to the services available through those providers;**		
F.	**a program sponsor shall ensure that a patient has access to a self-help group or support group, such as narcotics anonymous, either at the agency or through referral to a community group;**		
G.	**treatment services are provided by appropriately licensed staff.**		
7.32.8.26 DIVERSE POPULATIONS			
A.	**The program sponsor shall ensure that:**		
1.	**opioid treatment is provided regardless of race, ethnicity, gender, age, or sexual orientation;**		

2.	**the program facility is compliant with the Americans with Disabilities Act (ADA);**		
3.	**opioid treatment is provided with consideration for a patient's individual needs, cultural background, and values;**		
4.	**provider staff members are culturally competent;**		
5.	**unbiased language is used in the provider's print materials, electronic media, and other training or educational materials;**		
6.	**HIV testing and education are available to patients either at the provider or through referral;**		
7.	**a patient who is HIV-positive and who requests treatment for HIV or AIDS:** **(a) is offered treatment for HIV or AIDS either at the provider or through referral; and** **(b) has access to an HIV- or AIDS-related peer group or support group and to social services either at the provider or through referral to a community group; and**		
8.	**for patients with a communicable disease such as HIV, AIDS, or hepatitis C, the provider has a procedure for transferring a patient's opioid treatment to a non-program medical practitioner treating the patient for the communicable disease when it becomes the patient's primary health concern;**		
9.	**an individual who requires administration of opioid treatment medication only for relief of chronic pain is:** **(a) identified during the physical examination or assessment;** **(b) not admitted for opioid medication treatment; and** **(c) referred for medical services; and** **(d) for a patient with a chronic pain disorder who is also physically dependent the OTP makes a good faith effort to coordinate treatment and services with the medical practitioner treating the patient for pain management.**		
B.	**A program sponsor shall ensure that a policy and procedure is developed, implemented, and complied with for the treatment of female patients, to include requirements that:**		
1.	**pregnancy tests shall be administered and reviewed for all women of childbearing age prior to initiating a opioid treatment withdrawal procedure or medically supervised withdrawal;**		
2.	**appropriate staff members be educated in the unique needs of female patients; and**		

3.	**each female patient be informed about or referred to an appropriate support group, at the provider or in the community.**		
C.	**The program sponsor shall ensure that a policy and procedure is developed, implemented, and complied with for the treatment of pregnant patients, to include:**		
1.	**a requirement that priority be given to pregnant individuals seeking opioid treatment;**		
2.	**a requirement that the reasons for a pregnant individual's denial of admission to a provider be documented;**		
3.	**a requirement that a pregnant patient be offered prenatal care to include fetal assessment either at the program or through referral to a non-program medical practitioner;**		
4.	**a requirement that the program communicate with any non-program medical practitioners who are providing prenatal care to a pregnant patient, to coordinate opioid treatment and prenatal care, in accordance with all state and federal laws and regulations for the release of patient records or information; and document all such communications in the patient records;**		
5.	**a requirement that a staff member make a good faith effort to educate a pregnant patient who refuses prenatal care services on the importance of prenatal care;**		
6.	**a requirement that a staff member obtain a written refusal of prenatal care services that are offered either directly by the program or by referral, from a pregnant patient who refuses such services or referral to such services;**		
7.	**a requirement that a pregnant patient receiving comprehensive maintenance treatment before pregnancy be maintained at the pre-pregnancy dose of opioid medication, if effective;**		
8.	**a requirement that a pregnant patient be monitored by the program medical director to determine if pregnancy-induced changes in the elimination or metabolization of opioid treatment medication may necessitate an increased or split dose**		
9.	**a requirement that withdrawal treatment:** **(a) is strongly advised against before 14 weeks or after 32 weeks of gestation;** **(b) the program medical director reviews the case before initiating withdrawal and monitor it until withdrawal is complete;**		

10.	**a requirement that a pregnant patient discharged from the program be referred to a non-program medical practitioner and that a staff member document the name, address, and telephone number of the medical practitioner in the patient record.**		
D.	**A program sponsor who is officially notified by a correctional facility that a patient is in their custody shall ensure that the program:**		
1.	**makes efforts to obtain approval from the criminal justice system for the continued treatment of the patient by the program while the patient is incarcerated; and**		
2.	**if approval is obtained the program continues to treat the patient while the patient is incarcerated , within the limits of the program's ability to provide such treatment to the incarcerated patient; and**		
3.	**if approval is not obtained, the program's attempts to obtain approval are documented in the patient's record.**		
7.32.8.27 PREPAREDNESS PLANNING			
A.	**The program sponsor shall ensure that the program has:**		
1.	**a written plan to ensure uninterrupted dispensing of medication in the event of dispensing staff turnover; and**		
2.	**a written agreement with at least one other provider for the provision of opioid treatment medication to program patients in the event that the program is unable to provide services;**		
3.	**24-hour telephone answering service or other method to reach the program at all times; and**		
4.	**a list of all patients and the patients' dosage requirements available and accessible to program on-call staff members.**		
B.	**A program sponsor shall ensure that a written plan is developed and implemented for continuity of patient services if the program is voluntarily or involuntarily closed. Such planning shall include a disaster plan that addresses unforeseeable circumstances such as natural disaster or involuntary closure from any cause, and:**		
1.	**includes steps for the orderly transfer of patients to other programs, individuals, or entities that provide opioid treatment;**		

2.	**includes procedures for securing, maintaining, and transferring patient records according to federal and state law; and**		
3.	**the plan is reviewed and updated, as appropriate, at least once every 12 months.**		
7.32.8.28 PATIENT RECORDS			
A.	**The OTP program shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. The system shall comply with all federal and state requirements relevant to OTPs and to confidentiality of patient records.**		
B.	**Each patient record shall include:**		
1.	**the results of the physical examination;**		
2.	**the results of all assessments;**		
3.	**the treatment plan and all updates or revisions;**		
4.	**the results of laboratory tests and a description of any action taken based upon the results;**		
5.	**documentation of the patient's current dose and dosage history;**		
6.	**documentation of counseling provided to the patient;**		
7.	**dates and results of meetings or conferences regarding the patient's treatment;**		
8.	**documentation of the process used and factors considered in making decisions that impact a patient's treatment, such as whether to allow take-home medication and the frequency of laboratory drug detection tests; and**		
9.	**documentation of the agency's efforts to learn of multiple opioid treatment program enrollment;**		
10.	**documentation that the patient has received and understood information regarding the harmful effects of diversion of opioid treatment medication.**		
7.32.8.29 COMMUNITY RELATIONS			
A.	**A program sponsor shall ensure that policies and procedures are developed, implemented, and complied with to educate and promote understanding in the community about opioid treatment and include:**		
1.	**a mechanism for eliciting input from the community about the provider's impact on the community;**		

2.	**a requirement that the program sponsor or designee interface with community leaders to foster positive relations;**		
3.	**a requirement that the program sponsor or designee establish a liaison with community representatives to share information about the program;**		
4.	**a requirement that the agency have information on substance abuse and related health and social issues available to the public;**		
5.	**a mechanism for addressing and resolving community concerns about opioid treatment or the program's presence in the community; and**		
6.	**a mechanism that addresses getting approval for continued treatment in treatment or care facilities and correctional facilities.**		
B	**A program sponsor shall ensure that community relations efforts are documented and are evaluated at least once every 6 months.**		
C.	**A program sponsor shall comply with all valid county and municipal ordinances regarding community relations, and the department of health may consult with local governmental entities when enforcing this section.**		
7.32.8.30 DIVERSION CONTROL			
	The program sponsor shall ensure that a written plan is developed, implemented, and complied with to prevent diversion of opioid treatment medication from its intended purpose to illicit purposes. This plan shall assign specific responsibility to licensed and administrative staff for carrying out the diversion control measures and functions described in the plan. The program shall develop and implement a policy and procedure providing for the reporting of theft or diversion of medication to the relevant regulatory agencies, and law enforcement authorities.		

APPENDIX ZT

CLINIC AND PERSONNEL CHECK LIST

NEW MEXICO REGULATIONS FOR OPIOID TREATMENT PROGRAM

AGENCY: _____ DATE OF SITE VISIT: _____

SOTA: _____ OTHER: _____

	YES	NO	COMMENTS
1. Dates and times of operation posted.			
2. SOTA name and contact information are prominently displayed.			
3. Obtain a list of current counseling staff with licensure held.			
4. Obtain a list of each counselors work schedule (days and hours).			
5. Obtain a list of current pts being treated and check for staff/pt ratio.			
6. Observe for safety concerns inside the clinic (loitering, interactions, orderly, soliciting, bx, language etc).			
7. Observe for safety concerns outside the clinic (loitering, interactions, orderly, soliciting, bx, language etc).			
8. Observe for interactions between staff and patients (respectful, professional, efficient etc)			
9. Security guard on premises?			

10. General appearance, atmosphere, cleanliness acceptable (incl. bath rooms for pt and staff use and UA's).			
11. Is the director present? If not, identify who is in charge.			
12. Review current licenses: DEA, CARF, CSAT, Business and State Posted.			
13. Review current liability insurance covering program and employees.			
14. Review all current and past medical personnel records for required licensure, including, medical director, nursing and pharmacy.			
15. Review all current and past counseling personnel records for required licensure accepted for OTP counseling.			

Site:
Date of interview:

COUNSELOR QUESTIONNAIRE

1. What is your role as a counselor?

2. How many patients are typically on your caseload?

3. How often do you meet with patients?

4. What topics are commonly talked about in your sessions?

5. If a patient has a special need to talk to you how can they reach you?

6. Would you please describe the orientation process when you were hired?
    a. Have you read/reviewed the clinic P & P's?
    b. Were you trained in Trauma Informed Care?

7. Do you have adequate on-site supervision available to you?
    a. What types of concerns do you bring to supervision?

APPENDIX ZV

PERSONNEL Name/Title **List Clinical Supervisor/Supervisor assigned**	**DATE OF HIRE**	**LICENSURE type/# and expiration date**	**TRAINING indicate dates (Orientation, TIC, Recovery& Resiliency, Naloxone, Incident Reporting)**	**CLINICAL SUPERVISION/ date (group or individual)**
			ORIENT: TIC: REC & RES: NALOXONE: INC REPRORT:	
			ORIENT: TIC: REC & RES: NALOXONE: INC REPRORT:	
			ORIENT: TIC: REC & RES: NALOXONE: INC REPRORT:	
			ORIENT: TIC: REC & RES: NALOXONE: INC REPRORT:	
			ORIENT: TIC: REC & RES: NALOXONE: INC REPRORT:	

APPENDIX ZW

PATIENT RECORD AUDIT

NEW MEXICO REGULATIONS FOR OPIOID TREATMENT PROGRAM

AGENCY: _____ **DATE OF SITE VISIT:** _____

PATIENT IDENTIFIER: _____ **REVIEW TEAM:** _____

	YES	NO	COMMENTS
Date of Admission: _____			
NM Reg: 7.32.8.19 Admission 1. Patient meets the definition of opioid dependence.			
2. Fully documented physical exam with labs (TB, RPR) and drug testing conducted by the medical director or medical practitioner and complete within 14 days of admission.			
3. If the pt is a female of child bearing age, she receives a pregnancy test before initiating opioid treatment.			
4. Copy of informed consent to treatment is present and signed by the patient.			
NM Reg: 7.32.8.20 Assessment. & Tx Plans 1. Comprehensive intake assessment at admission with DSM diagnosis of Opiate Dependence; screening and documentation of any co-occurring diagnosis; referral for MH/SA/other services if indicated and f/u w/provider; signed by a licensed clinician and in pt file within 24 hours of admission. NM Reg: 7.32.8.20 A. and 7.32.8.25 C.			(Date of Assessment/Staff name and credentials)
2. Initial treatment plan is completed at admission and in patient file within 24 hours, signed by patient and clinician. NM Reg: 7.32.8.20(A)			(Date of ini tx plan/staff name and credentials)

	YES	NO	COMMENTS
3. Individualized treatment plan is completed within 30 days, or by the 3rd face-to-face contact, signed by patient and clinician. NM Reg: 7.32.8.20(B)			(date of ind tx plan/staff name and credentials)
4. NM Reg: 7.32.8.20 (D): All assessments. and/or treatment plans include:			
1. Description of patients presenting issue, BH symptoms or issue requiring treatment.			
2. A list of medical services, including medications.			
3. Recommendations for further assessment or exams if indicated.			
4. Recommendations for treatment needed by patient, i.e. MH treatment if indicated.			
5. Recommendations for ancillary services or other services needed by patient if indicated.			
6. Signature & professional credentials, printed name & date signed by staff member completing document.			
7. Updated and revised treatment plans document a summary of progress/lack of progress for each goal and the programs response.			
8. Patient signature is present or documentation that the patient 'refused to sign'			
5. Treatment plans are reviewed and updated every 90 days. NM Reg: 7.32.8.20 (E)			Dates of reviews/staff name and credentials

	YES	NO	COMMENTS
NM Reg: 7.32.8.21 Dosage 1. Initial dose of Methadone does not exceed 30 mg. NM Reg: 7.32.8.21 4.			
2. If withdrawal symptoms are not suppressed, an additional 10mg may be administered after 30 minutes and there is documentation that the 30mg did not suppress patient withdrawal symptoms.			
NM Reg: 7.32.8.22 Drug Screening 1. Documentation of UA's and results of the UA's (min. 8 per yr). NM Reg: 7.32.8.22 B.			
2. If UA's are positive for illicit substances, it's documented in the pt record along with any actions taken. May include: documentation of a plan to address in counseling, and/or refer the patient for additional SA support services, and/or placed on withdrawal protocols. NM Reg: 7.32.8.22 E.			Date of UAs indicate if pos for illicits/ y/n notes address UA
NM Reg: 7.32.8.23 Take Home Medication 1. Does the patient have take-home privileges? If yes, patient is compliant with all requirements:			
1. Abstinence from recent abuse of drugs or alcohol (see UA results).			
2. Regular program attendance (see treatment plan and progress notes).			
3. Absence of known criminal activity (see progress notes).			
4. Absence of serious behavioral health problems at the program (see progress notes).			

	YES	NO	COMMENTS
NM Reg. 7.32.8.24 Withdrawal Tx and Medically Supervised Dose Reduction: 1. Is the patient on withdrawal protocols either voluntarily or involuntarily? If yes, then there is doc of the following:			
a) The patient is offered or provided additional counseling, or additional counseling is made available to support the patient.			
b) The patient is offered or provided with ancillary services, such as self-help groups or referrals for other services.			
c) Counseling services are increased before discharge and the patient is informed they can be re-admitted or referred to another program if they relapse (if a voluntary withdrawal).			
d) The patient's withdrawal treatment is medically supervised (seen regularly by the doctor or other health care provider in the clinic).			
e) If the patient is a female of child bearing age, she receives a pregnancy test before initiating withdrawal protocols.			
Other observations:			

ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Children, Youth and Families	
	1. Log No: ACYF-CB-IM-14-03	**2. Issuance Date:** October 23, 2014
	3. Originating Office: Children's Bureau	
	4. Key Words: Preventing Sex Trafficking and Strengthening Families Act, Title IV-E Plans, Trafficking, APPLA, AFCARS, Family Connections Grants, Adoption and Guardianship Incentives	

INFORMATION MEMORANDUM

TO: State, Tribal and Territorial Agencies Administering or Supervising the Administration of Title IV-E and/or Title IV-B of the Social Security Act

SUBJECT: NEW LEGISLATION - Public Law 113-183, the Preventing Sex Trafficking and Strengthening Families Act

LEGAL AND RELATED REFERENCES: Titles IV-B, IV-E, and section 1114A of the Social Security Act (the Act) as amended by Public Law 113-183, enacted September 29, 2014

PURPOSE: To inform states and Tribes of the enactment of the Preventing Sex Trafficking and Strengthening Families Act and provide basic information on the new law, including title IV-E plan changes, new case plan requirements and definitions, additions to the Adoption and Foster Care Analysis and Reporting System (AFCARS), modifications to the Family Connection grants, Chafee program, and reauthorization of the Adoption and Guardianship Incentive Program.

INFORMATION: The President signed the Preventing Sex Trafficking and Strengthening Families Act, Public Law (P.L. 113-183) into law on September 29, 2014. The law amends the title IV-E foster care program to address trafficking, limits another planned permanency living arrangement (APPLA) as a plan for youth, and reauthorizes and amends Family Connections Grants and the Adoption Incentives Program. Some of the major changes are described below (please refer to the attached law for the complete amendments).

Family Connection Grants Program

- Reauthorizes family connection grants at the current authorization level of $15 million for 2014 under section 427 of the Social Security Act.
- Permits HHS to make family connection grants available to institutions of higher education.
- No longer requires the Secretary to reserve $5 million each fiscal year for kinship navigator programs.
- These provisions are effective as if P.L. 113-183 was enacted on October 1, 2013.

Title IV-E requirements for identifying, reporting and determining services to victims of sex trafficking

- Modifies existing or adds new title IV-E plan requirements that apply to state and tribal title IV-E agencies as follows:
  - Modifies section 471(a)(9) to require that:
    - within 1 year of enactment (by September 29, 2015), title IV-E agencies must demonstrate that they have: 1) consulted with other specified agencies having experience with at risk youth and; 2) developed policies and procedures (including caseworker training) to identify, document, and determine appropriate services for:
      - Any child or youth in the placement, care or supervision of the title IV-E agency who is at-risk of becoming a sex trafficking victim or who is a sex trafficking victim (including those not removed from home; those who have run away from foster care and under age 18 or such higher age elected under 475(8); and youth not in foster care who are receiving services under the Chafee Foster Care Independence program (CFCIP) (477)), and at the option of the agency, youth under age 26 who were or were never in foster care. (471(a)(9)(C)(i)[1])
    - within 2 years of enactment (by September 29, 2016), title IV-E agencies must demonstrate that they are implementing these policies and procedures. (471(a)(9)(C)(ii))
  - Adds a new title IV-E plan requirement at 471(a)(34) that title IV-E agencies must:
    - Report immediately (no later than 24 hours) to law enforcement children or youth described under 471(a)(9)(C)(i)(I)) who the agency identifies as being a sex trafficking victim. (Must begin within 2 years of enactment (by September 29, 2016)).
    - Report annually to HHS the total number of children and youth described under 471(a)(9)(C)(i)(I)) who are sex trafficking victims. (Must begin within 3 years of enactment (by September 29, 2017)).
  - Adds a new title IV-E plan requirement at 471(a)(35) that requires:
    1) within 1 year of enactment (by September 29, 2015), title IV-E agencies to develop and implement protocols to:
    - locate children missing from foster care,
    - determine the factors that lead to the child's being absent from foster care and to the extent possible address those factors in subsequent placements,
    - determine the child's experiences while absent from care, including whether the child is a sex trafficking victim, and
    - report related information as required by HHS. (471(a)(35)(A))

    2) within 2 years of enactment (by September 29, 2016), title IV-E agencies to develop and implement protocols to report children or youth described under 471(a)(9)(C)(i)(I)) immediately (no later than 24 hours after receiving information) on missing or abducted children to law enforcement for entry into the National Crime Information Center (NCIC) database. (471(a)(35)(B))
- HHS must report to Congress the number of children and youth reported by title IV-E agencies as sex trafficking victims, within 4 years of enactment (by September 29, 2018) and annually thereafter. (471(d))

[1] All citations are to the SSA as amended by P.L. 113-183.

- Defines "sex trafficking victim" in section 475(9) of the Act as a victim of sex trafficking (as defined in section 103(10) of the Trafficking Victims Protection Act of 2000)[2] or a severe form of trafficking in persons (described in section 103(9)(A) of the Trafficking Victims Protection Act of 2000).[3]

Title IV-E requirements related to the reasonable and prudent parent standard and developmentally appropriate activities for children in foster care

- Modifies the existing title IV-E plan requirement at 471(a)(10) requiring state and tribal licensing authorities to: permit the use of the "reasonable and prudent parenting standard" as defined in section 475(10)[4] in their standards for foster family homes and child care institutions; require child care institutions to have an on-site official authorized to apply the reasonable and prudent parent standard; and have policies for foster parents and private entities (under contract) applying the reasonable and prudent parent standard to ensure appropriate caregiver liability when approving an activity for a foster youth. Each child care institution's authorized official must have the same training on the "reasonable and prudent parent standard" as required under section 471(a)(24) of the Act for foster parents.
- Amends the existing title IV-E requirement at section 471(a)(24) of the Act to require title IV-E agencies to certify that foster parents have skills and knowledge on the "reasonable and prudent parent standard".
- HHS must provide technical assistance on best practices for strategies to assist foster parents in applying the reasonable and prudent parent standard, while allowing children to participate in normal and beneficial activities (section 111(a)(3) of P. L. 113-183).
- These provisions are effective 1 year after enactment (September 29, 2015) unless a delayed effective date is approved. A limited period of delay is permitted when the Secretary of the U.S. Department of Health and Human Services determines that legislation (other than legislation appropriating funds) is required for a title IV-E agency to comply with the plan requirements under title IV-E of the Act imposed by the amendment. The "delayed effective date" is defined as the 1st day of the 1st calendar quarter after the 1st regular session of the state legislature or tribal governing body after enactment. If the state/Tribe has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the legislature.[5]

Adds new title IV-E/IV-B case plan and case review system requirements for youth with a plan of APPLA and children over age 14

- Modifies the title IV-E plan at section 471(a)(16) and title IV-B plan at 422(b)(8) of the Act with new requirements for agencies to modify their case review system (in section 475(5) of the Act) as follows:
    - Limits APPLA as a permanency plan for youth age 16 and older (section 475(5)(C)(i) of the Act).

[2] Section 103(10) of TVPA: Sex trafficking: The term "sex trafficking" means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

[3] Section 103(9)(A) of TVPA: Severe forms of trafficking in persons: The term "severe forms of trafficking in persons" means—(A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age.

[4] "Reasonable and prudent parent standard" is defined as the standard characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth, that a caregiver must use when determining whether to allow a child in foster care under the responsibility of the state/Tribe to participate in extracurricular, enrichment, and social activities. Caregiver (for this purpose only), is a foster parent or designated official at a child care institution.

[5] This means, for example, that ACF may approve a delayed effective date of 10/1/2015 (for this provision) when the 1st regular legislative session that is held after September 29, 2014 closes between July 1, 2015 and September 30, 2015.

    - Requires title IV-E agencies to follow additional case review and case plan requirements in sections 475A, 475(5)(B), and (C)(i) of the Act for all children in foster care with a permanency plan of APPLA including that the title IV-E agency must:
        - Document at each permanency hearing the efforts to place a child permanently with a parent, relative, or in a guardianship or adoptive placement (sections 475(5)(C)(i) and 475A(A)(1) of the Act).
        - Implement procedures to ensure that the court or administrative body conducting the permanency hearing asks the child about his/her desired permanency outcome and makes a judicial determination at each permanency hearing that APPLA is the best permanency plan for the child and compelling reasons why it's not in the best interest of the child to be placed permanently with a parent, relative, or in a guardianship or adoptive placement (section 475A(a)(2) of the Act).
        - Document at the permanency hearing and the 6 month periodic review the steps the agency is taking to ensure that the foster family follows the "reasonable and prudent parent standard" and whether the child has regular opportunities to engage in "age or developmentally-appropriate activities" (sections 475(5)(B) 475A(a)(3) of the Act).
- Defines "age or developmentally-appropriate" as suitable, developmentally appropriate activities for children of a certain age or maturity level based on the capacities typical for the age group and the individual child (section 475(11) of the Act).
- For children age 14 and older:
    - The case plan must document the child's education, health, visitation, and court participation rights, the right to receive a credit report annually, and a signed acknowledgement that the child was provided these rights and that they were explained in an age appropriate way (section 475A of the Act),
    - The case plan must be developed in consultation with the child, and at the option of the child, 2 members of the case planning team, who are not the caseworker or foster parent (sections 475(1)(B) and (5)(C)(iv)of the Act),
    - The case plan and permanency hearing must describe the services to help the youth transition to successful adulthood (formerly at age 16) (sections 475(1)(D) and (5)(C)(i) of the Act),
    - The title IV-B/IV-E agency must provide a copy of his/her credit report annually and assistance in fixing any inaccuracies (formerly age 16) (section 475(I) of the Act).
- These provisions are effective 1 year after enactment (September 29, 2015). Title IV-E/IV-B Tribes have 3 years to implement the limit on APPLA as a permanency plan for youth age 16 and older (section 475(5)(C)(i) of the Act).

Providing important documents to youth aging out of foster care

- As part of the case review system in section 475(5)(I) of the Act, the title IV-B/IV-E agencies must provide a youth aging out of foster care at age 18 (or 19, 20 or 21 as elected by the agency under section 475(8) of the Act) with his/her birth certificate, Social Security card, driver's license or identification card, health insurance information, and medical records. Children who have been in foster care for less than 6 months are exempt.
- These provisions are effective 1 year after enactment (September 29, 2015).

Relative notification and sibling definition

- Modifies the title IV-E plan requirement in section 471(a)(29) of the Act for relative notification to include notifying parents of the child's siblings.

- Defines siblings in section 475(12) of the Act to mean an individual who is considered by state law to be a sibling or who would be considered a sibling under state law is it not were for a disruption in parental rights, such as a termination of parental rights or death of parent.
- These provisions are effective upon enactment unless a delayed effective date is approved. A limited period of delay is permitted when the Secretary of the U.S. Department of Health and Human Services determines that legislation (other than legislation appropriating funds) is required for a title IV-E agency to comply with the plan requirements under title IV-E of the Act imposed by the amendment. The "delayed effective date" is defined as the 1st day of the 1st calendar quarter after the 1st regular session of the state legislature or tribal governing body after enactment. If the state/Tribe has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the legislature.[6]

Adoption and Guardianship Incentive Program- applies to state title IV-E agencies only

- Renames the program "Adoption and Legal Guardianship Incentive Payments."
- Reauthorizes at the current authorization level of $43 million for each fiscal year through 2016.
- Creates new incentive categories that replace the old categories. Each fiscal year, a state is eligible for incentive funds in the following categories and award levels:
    - $5,000 for improving the rate of foster child adoptions.
    - $10,000 for improving the rate of older child adoptions and older foster child guardianships (age 14 and older).[7]
    - $7,500 for improving the rate of pre-adolescent adoptions and pre-adolescent foster child guardianships (ages 9-13).[8]
    - $4,000 for improving the rate of foster child guardianships.[9]
- The base rate is the average rate for the immediately preceding 3 fiscal years or the rate for the prior fiscal year. For fiscal year 2014, states receive an amount equal to half the sum of the total award currently in effect and the total award under the new categories. Also provides a pro rata adjustment if insufficient funds are available.
- Creates an incentive for timely adoptions and guardianships finalized during any fiscal years 2013-2015 if the other incentive awards are less than the appropriation. A state may be eligible to receive an award for a fiscal year if the average number of months from removal to placement in a finalized adoption or guardianship is less than 24 months.
- Allows states to spend the incentives over a 36 month period instead of a 24 month period.
- The guardianship incentive is available for a child who leaves foster care to live with a legal guardian if either:
    - The child was removed from the home pursuant to a voluntary placement agreement or judicial determination that continuation in the home is contrary to the welfare of the child, return to the home is not an appropriate option, the child demonstrates a strong attachment to the legal guardian, the legal guardian has a strong commitment to caring permanently for the child, and if over 14 years of age, the child is consulted regarding the legal guardianship arrangement; or

[6] See footnote 5.

[7] The award amount for older child adoptions and guardianships is based on a calculation that involves the base rate of adoptions/guardianships during the fiscal year and the number of children age 14 and older in foster care in the state on the last day of the previous fiscal year.

[8] The award amount for pre-adolescent adoptions and guardianships is based on a calculation that involves the base rate of adoptions/guardianships during the fiscal year and the number of children ages 9-13 in foster care in the state on the last day of the previous fiscal year.

[9] The award amount for foster child adoptions and foster child guardianships are based on a calculation that involves the base rate of adoptions/guardianships during the fiscal year and the number of children in foster care in the state on the last day of the previous fiscal year.

    - Alternative procedure used by the state to determine that the legal guardianship is an appropriate option for the child.
- States may not use incentive payments to supplant federal or non-federal funds for services under title IV-B or IV-E.

Successor guardians

- Allows continuation of title IV-E kinship guardianship assistance payments if the relative guardian dies or is incapacitated and a successor legal guardian is named in the agreement (or any amendments to the agreement) (section 473(d)(3)(C) of the Act).
- This provision is effective upon enactment (September 29, 2014).

Title IV-E Adoption Assistance Program savings reporting

- Modifies section 473(a)(8) of the Act to require title IV-E agencies to calculate and report annually the savings from the agency de-linking title IV-E adoption assistance eligibility from the Aid to Families with Dependent Children (AFDC) eligibility requirements, the methodology used to calculate the savings, how savings are spent, and on what services. Title IV-E agencies must use a methodology specified by the Secretary or may propose an alternative for the Secretary's approval.
- Title IV-E agencies must spend the savings on title IV-B and IV-E programs; 30% of which must be spent on post-adoption services, post-guardianship services and services to support positive permanent outcomes for children at risk of entering foster care. Two-thirds of the 30% must be spent on post-adoption and post-guardianship services.
- Title IV-E agencies must use the savings to supplement and not supplant any Federal or non-Federal funds used to provide any service under title IV-B or IV-E.
- These provisions were effective as of October 1, 2014.

New Chafee Foster Care Independence Program (CFCIP) purpose and increased appropriations beginning in 2020

- Increases the appropriation by $3m to $143,000,000 beginning in FY 2020 (section 477(h)(1) of the Act).
- Amends the purposes of the CFCIP at section 477(a)(8) of the Act to ensure that children who are likely to remain in foster care until age 18 have on-going opportunities to engage in "age or developmentally-appropriate" activities.
- This provision is effective 1 year after enactment (September 29, 2015) unless a delayed effective date is approved. A limited period of delay is permitted when the Secretary of the U.S. Department of Health and Human Services determines that legislation (other than legislation appropriating funds) is required for a title IV-E agency to comply with the plan requirements under title IV-E of the Act imposed by the amendment. The "delayed effective date" is defined as the 1st day of the 1st calendar quarter after the 1st regular session of the state legislature or tribal governing body after enactment. If the state/tribe has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the legislature.[10]

New Adoption and Foster Care Analysis and Reporting System (AFCARS) data elements

- Amends section 479 of the Act to require title IV-E agencies to report information on children in foster care who are identified as sex trafficking victims and children who enter foster care after a finalized adoption or legal guardianship.

Annual state child welfare outcomes report (section 479A of the Act)

- Beginning in FY 2016, HHS must report state-by-state data on children in foster care who are:

[10] See footnote 5.

- pregnant or parenting.
- placed in a child care institution or other non-foster family home setting including:
  - the number of children in the placement, their ages, and whether they have a permanency plan of APPLA,
  - their duration in placement and the type of child care institution placed (e.g., group home, residential treatment, shelter, or other congregate care setting),
  - the number of foster children placed in each setting, and
  - any clinically diagnosed special need and the extent of special education or services provided in the placement.

- HHS must consult with states and other child welfare-related organizations on other issues and data to report on using AFCARS, NYTD and other data available to HHS.

Reports to Congress

- HHS must report to Congress on children who run away from foster care and their risk of being sex trafficking victims, their characteristics, factors associated with running away, experiences while absent from care, and trends, among other things (section 105 of P. L. 113-183).
- HHS must report to Congress on agencies implementation of and best practices for the case planning amendments in 475A (b), 475(1)(B), (D), and (5)(C) of the Act (section 113(e) of P. L. 113-183).
- These reports are due to Congress within 2 years of enactment (by September 29, 2016).

National Advisory Committee on the Sex Trafficking of Children and Youth in the United States (section 1114A of the Act)

- Within 2 years of enactment, HHS must establish and appoint a National Advisory Committee on the Sex Trafficking of Children and Youth in the United States to, among other things advise on practical and general policies on improving the national response to sex trafficking and develop best practices.

The Children's Bureau will provide further guidance through Program Instructions at a later date.

INQUIRIES TO: Children's Bureau Regional Program Managers

/s/
Mark Greenberg
Acting Commissioner, ACYF

/s/
JooYeun Chang
Associate Commissioner, CB

Attachments:
A – Public Law 113-183
B – CB Regional Office Program Managers