Clinical Practices Advisory Panel
Report on
Assertive Community Treatment

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Clinical Practices Advisory Panel Report on Assertive Community Treatment

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Clinical Practices Advisory Panel Report on Assertive Community Treatment

Introduction

The Clinical Practice Advisory Panel (CPAP) has the mission to review Assertive Community Treatment (ACT) and other evidence-based practices (EBP) from the perspective of consumers, advocates and the CRT program staff. The reasons for implementing EBPs for people with mental illnesses is to ensure that the most effective mental health services are provided and that funding is used efficiently and effectively (Lewin Group, 2000). This statement from a review of ACT for the Substance Abuse and Mental Health Services Administration (SAMHSA) is only part of the criteria for the CPAP mental health practices reviews of EPBs. Inclusion and respect for the people who are the consumers of mental health services is equally important. The Vermont Department of Mental Health System Values for Treatment and Recovery (see Appendix B) and the National Consensus Statement on Mental Health (see Appendix C) are very important criteria. The evidence for an EBP is also a criterion. All practices that claim to be evidence-based have do not have sufficient research to support the claim of being an EBP. Further, the outcomes that are evidence based may not be the outcomes of interest to CRT programs in Vermont. These criteria will be used in this report to examine ACT. The examination of ACT will be followed by recommendation for the implementation of ACT at Vermont CMHCs.

Assertive Community Treatment (ACT) is more than a mental health practice like Illness Management and Recovery, Supported Employment or other EBPs that the Clinical Practices Advisory Panel (CPAP) has been reviewing. ACT is a service delivery

model that when implemented requires changing the structure of a Community Rehabilitation and Treatment program (CRT) at a community mental health center (CMHC). Currently in Vermont only Northeast Kingdom Human Services has an ACT program.

Development of Assertive Community Treatment

With the Community Mental Health Centers Act of 1963, the field of mental health care received an official mandate to revolutionize care of individuals with mental illnesses in the direction of providing decentralized, local community-based treatment as opposed to institutional care for people with even the most severe psychiatric difficulties (Test and Stein, 2000). Leonard Stein and Mary Ann Test made observations that many individuals with a severe mental illness were being discharged from inpatient care in stable condition, only to return after a relatively short time, while they were working at the Mendota Mental Health Institute in Madison, Wisconsin. Their answer to this problem was to develop the ACT model that was originally called Training in Community Living (Bond et al., 2001; Lewin Group, 2000; Phillips, Burns, Edgar, et al., 2001).

Many case management models have been developed including the clinical case management model, the intensive case management model, and ACT that is also known as PACT with the P for Program (Mueser et al., 1998; Robinson & Toff-Bergman, 1990; Harris & Bergman, 1993). There are also several more names used to describe essentially the same practice that include the full service model, assertive outreach, mobile treatment teams, and continuous treatment teams (Bond et al., 2001).

ACT is primarily for individuals with a severe and persistent mental illnesses (SPMI). The definition of SPMI by the National Institute of Mental Health (NIMH) is an,

"adult 18 years and over, with a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment, but for whom long-term 24-hour care in a hospital, nursing home, or protective facility is unnecessary or inappropriate." These consumers among the CRT population have experienced the most intractable symptoms of severe mental illness and they have the greatest level of functional impairment. They are often heavy users of inpatient psychiatric services, and they frequently have the poorest quality of life (Phillips, Burns, Edgar, et al., 2001). These are the consumers for whom ACT was developed, but ACT has also been appropriately used with people with several disorders including posttraumatic stress disorder, anorexia, and obsessive-compulsive disorder (Allness & Knoedler, 1998).

Description of Assertive Community Treatment

Stein and Test designed an individualized service delivery model that provides all the services available in a hospital in the community. ACT is sometimes thought of as a hospital without walls. A team of professionals assumes direct responsibility for providing the specific mix of services needed by a consumer, for as long as the consumer has the need. The services are available 24 hours a day, seven days a week, and are provided in the community where the problems arise and the consumer needs support and to use her/his skills. Consumers are not expected to learn skills in the clinic and to generalize those skills to "real-life" situations. (Phillips, Burns, Edgar, et al., 2001).

ACT teams typically consist of from 10 to 12 staff members. The fields represented on the team include psychiatry, nursing, social work, and professionals with

other types of expertise, such as substance abuse treatment and vocational rehabilitation. The ACT principles are that a team must be (1) large enough to include members from the required professions and (2) to provide coverage seven days a week, (3) but also be small enough that each team member is familiar with every consumer. A staff-to-consumer ratio of 1 to 10 is recommended, but even a lower ratio may be needed if the consumers have more intense needs, or in rural areas where long distances must be traveled (Phillips, Burns, Edgar, et al., 2001).

Collaboration among team members to integrate interventions and to monitor each consumer's responses is essential to allow interventions to be adjusted quickly to meet the consumer's changing needs. The services provided are the services a consumer needs and not limited to a specific list of interventions. Services include any that are needed to support the consumer's optimal integration into the community. The team does not broker services, rather the team members are the service providers in the ACT model (Phillips, Burns, Edgar, et al., 2001).

Team members need to help other team members and to consult with them about their specialty. They should also be cross-trained in each other's jobs as far as is possible. The daily team meeting that reviews each consumer's status and the team planning jointly is the glue that holds ACT together. ACT can be modified to meet a clinic's needs or to target a specific group of consumers' needs, but its basic principles summarized in Table 1 should remain constant (Phillips, Burns, Edgar, et al., 2001). The key principals developed by Gary Bond, the foremost authority on ACT are summarized in Table 2, which reinforce the conceptualization of ACT principles presented in Table 1.

Table 1
Ten principles of Assertive Community Treatment

1.	Services are targeted to a specified group of individuals with severe mental illness.
2.	Rather than brokering services, treatment, support, and rehabilitation services are provided directly by the assertive community treatment team.
3.	Team members share responsibility for the individuals served by the team.
4.	The staff-to-consumer ratio is small (approximately 1 to 10).
5.	The range of treatment and services is comprehensive and flexible.
6.	Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.
7.	There is no arbitrary time limit on receiving services.
8.	Treatment and support services are individualized.
9.	Services are available on a 24-hour basis.
10.	The team is assertive in engaging individuals in treatment and monitoring their progress.

(Phillips, Burns, Edgar, et al., 2001)

Table 2
Key principles of Assertive Community Treatment

- Multidisciplinary Staffing
- Integration of Services
- Team Approach
- Low Patient-Staff Ratios
- Locus of Contact in the Community
- Medication Management
- Focus on Everyday Problems in Living
- Rapid Access
- Assertive Outreach
- Individualized Services
- Time-unlimited Services

(Bond et al., 2001)

The critical components of ACT services are summarized in Table 3 that was constructed form an extensive literature review and by questioning ACT experts. The model defined in Table 3 is essentially the same as the first study of ACT components by Stein and Test in 1980 with the addition of maximum team caseload and the inclusion of consumers on the team (Lewin Group, 2000).

Table 3
Critical ACT Components and Operational Definitions

Critical Components	Operational Definition or Range	
	Literature	Expert Opinion
Admission criteria	Only individuals with SPMI	Explicit admissions criteria
Time limits	Until consumer treatment goals are met	Consumer served on a time unlimited basis
Services	Individualized assessment and treatment planning; case management; crisis intervention; individual supportive therapy; medication prescription and monitoring; substance abuse services; work-related services; support for Activities of Daily Living (ADL); social, interpersonal relationship, and leisure time skill training; education, support, and consultation to consumers' families and other supports; coordination of hospital admissions and discharges; other support services7	
Staff-to-consumer ratio	1 FTE staff per 15 consumers	1 FTE staff per 10 consumers
Maximum team caseload size	120	98
Team leader	Team leader is qualified behavioral health practitioner (time unspecified)	Team leader has at least a master's in behavioral health field and works 40 hours per week
Psychiatrist on team	1 team member (time unspecified)	1 FTE
Nurse on team	1 team member (time unspecified)	3 FTEs
Peer specialist on team	Consumers involved as team members providing direct services	
Team availability	All services available during regular business hours (no weekends, holidays); afterhours crisis intervention services available through ACT team or contracted service	All services available 24 hours per day, 7 days per week; after-hours on-call system for team member
Direct provision of services by team members	Shared caseload	Shared caseload; at least 90% of consumers have direct contact with more than 1 staff member per week
Place of treatment	75% of service time in vivo	80% of service time in vivo
Frequency of service contacts	Multiple, based on clinical needs of the consumer (at least 2 contacts)	At least 4 contacts per week per consumer; at least 4 contacts per month with consumer's family or support system
Frequency of team case reviews	5 times per week	7 days per week

(Lewin Group, 2000)

Table 4 is a compilation of the services provided by ACT team members. It was compiled from numerous sources, but it isn't intended to be an all inclusive list. Rather, it is presented to show the breadth of services reported by ACT teams in the literature. Additional services may be provided if the service is needed by a consumer.

Table 4
Services provided by Assertive Community Treatment team members

Rehabilitative approach to daily living skills		**Health promotion**	
	Grocery shopping and cooking		Provide preventive health education
	Purchase and care of clothing		Provide preventive health education
	Use of transportation		Conduct medical screening
	Help with social and family relationships		Schedule maintenance visits
Family involvement			Provide liaison for acute medical care
	Crisis management		Provide reproductive counseling and sex education
	Counseling and psychoeducation with family and extended family	**Medication support**	
	Coordination with family service agencies		Order medications from pharmacy
Work opportunities			Deliver medications to consumers
	Help to find volunteer and vocational opportunities		Provide education about medication
	Provide liaison with and educate employers		Monitor medication compliance and side effects
	Serve as job coach for consumers	**Housing assistance**	
Entitlements			Find suitable shelter
	Assist with documentation		Secure leases and pay rent
	Accompany consumers to entitlement offices		Purchase and repair household items
	Manage food stamps		Develop relationships with landlords
	Assist with redetermination of benefits		Improve housekeeping skills
Financial management		**Counseling**	
	Plan budget		Use problem-oriented approach
	Troubleshoot financial problems (for example, disability payments)		Integrate counseling into continuous work
	Assist with bills		Ensure that goals are addressed by all team members
	Increase independence in money management		Promote communication skills development
			Provide counseling as part of comprehensive rehabilitative approach

Recovery Principles and Assertive Community Treatment

Coercion and outpatient commitment are fears related to ACT that are both incompatible with consumer choice (Lewin Group, 2000). The challenge of implementation is to be not too assertive with the ACT practice. The values of consumers, advocacy organizations, agencies and the state need to be the constraint on the implementation of ACT, because of the potential of being a coercive treatment practice.

> Coercion is any action the “coerced” individual says it is. For example, coerced hospitalization is when an individual feels forced to accept hospitalization (Hiday, 1992).
>
> The NIMH defines coercion as “a wide range of actions taken without the consent of the individual involved” (Diamond, 1996).
>
> The use of social control to protect and bring treatment to individuals with a mental illness, relieve illness-induced suffering, and protect others (Hiday, 1996).

Team members can have difficulty adjusting their professional values and practice to the ACT approach (Center for Psychiatric Rehabilitation, 1997). Many people are very uncomfortable with ACT because they believe the methodology is inherently coercive. This is based on the level of control in the method and the unlimited time a person may receive services. The main ethical challenge is often about the degree to which staff “assertively” push services with medication often being the center of the discussion (Lewin Group, 2000).

In one study mental health workers were very uncomfortable with the amount of control they had to exercise over consumers who were on probation or parole (Solomon & Draine, 1995). The staff reported that the intensive supervision of ACT leads to increased reincarceration, because staff members are aware of violations (Solomon & Draine, 1995). This seems to be a staff and agency issue more than a criticism of ACT. Probation and parole are realities of a person's life.

An agency will never work well if consumers and the staff believe the ACT program is working against their principles and beliefs. When ACT or any other practice is implemented the management, staff and consumer advisory team need to monitor the practice and make changes if the practice becomes coercive. The *Vermont Department of Mental Health System Values* and The *National Consensus Statement on Mental Health* (see Appendices B and C) can be used as guidelines to frame the discussion.

Assertive Community Treatment Research

The ACT model was first evaluated by the developers in the early 1970s and over time ACT has probably been researched more than any other treatment model (Lewin Group, 2000). By the beginning of this decade more than 40 well controlled studies of ACT had been completed (Lewin Group, 2000), but there hasn't been significant additional research since that time though many articles have been written (personal communication with Kim Mueser). This literature has been summarized in several comprehensive reviews (e.g., Burns and Santos, 1995; Lewin Group, 2000; and Mueser, et al., 1998).

Though the number of randomized controlled trials (RCT) is extensive the research isn't without its challenges. Major challenges to the research methodology are

the programs being examined in the RCTs being in very different communities, and being under very different management from higher systems levels. Therefore, comparisons are difficult. For example, the negligible effects for time spent in jail in a study by Solomon and Drain(1998) may be more a function of the quality of collaboration between the mental health system, and the court and correction systems (Lewin Group, 2000). This line of research (Solomon & Draine,1995) is also the source of most the other negative outcomes reported. These results may be accounted for by the ACT program being embedded in a very difficult community where the clients were just released from jail. Other challenge to the research methodology are the symptoms of the participants not being measured with common assessment tools and the measurement methods having been imprecise (Mueser et al., 1998), which makes comparison and interpretation of results much more difficult to interprit.

A challenge the users of the outcome data face has to do with expectations for outcomes. For example, there is modest support for a reduction in psychiatric symptoms for consumers who receive services from an ACT team (Bond et al., 2001; Lewin Group, 2000). However, there is also a possible logical error by many users of the outcome data who expect significant changes in symptoms in an ACT program. Based on strict entry criteria that only accept people with SPMI at the highest level of need and the concept of unlimited term of treatment, there may not be a strong expectation that symptoms will be significantly reduced. Though symptoms may increase and decrease over time (Mueser et al., 1998).

There are numerous types of outcomes that that have been studied including clinical, cost, program and system outcomes.

The clinical outcomes most studied are substance use, social functioning (quality of life), housing stability, medication compliance, and hospitalization rates, which relate to a consumer's need for inpatient services due to increased symptoms and environmental factors as well as simply cost (Bond et al., 2001; Lewin Group, 2000). Of these clinical outcomes hospitalization rates (reduction of inpatient days), housing stability and consumer's quality of life have the strongest positive findings (Lewin Group, 2000). The findings for other outcomes are weak, but they are at least equal to other practices (Drake, 1998).

The variables studied are interrelated. For example, housing stability, which can be viewed as an environmental variable, has often been associated with consumers' inpatient days. Increased housing stability is positively correlated with having fewer inpatient days. Most studies that examined housing stability found this outcome (Bond et al., 2001; Lewin Group, 2000). Also, increases in quality of life have been found in many studies that were at least slightly positive (Bond et al., 2001; Lewin Group, 2000), but these outcomes may be related to increased housing stability and a reduction in hospital stays (Mueser et al., 1998), which were also found in the studies. It is quite often hard to evaluate individual research outcomes in isolation. They need to be taken as a whole.

Medication compliance and co-occurring mental health and substance use disorders have been examined as noted above. The results in both areas have been mixed, which may be related to the methodological challenges already discussed. Only four studies reviewed by the Lewin Group examined medication compliance and the results were mixed with two studies having positive outcomes and two having no

significant change compared to the control group (Lewin Group, 2000). Early studies that included consumers with co-occurring disorders didn't find significant changes in substance use, but Drake et al. (1998) did find a significant reduction in substance use in the ACT group, which may be related to improvements to co-occurring treatment developed by Drake and his associates at Dartmouth.

Cost savings in ACT are attributable to reduced very expensive inpatient days (Bond et al., 2001; Lewin Group, 2000) exactly in the same way Dialectical Behavior Therapy (DBT), another intense therapy is found to be cost effective. **ACT isn't ever inexpensive**, but it has been found to be less expensive. The Lewin Group based on their studies of ACT has developed an Excel spreadsheet (http://www.lewin.com/NR/rdonlyres/4925287F-FFC5-460E-8F3B-4822D6B17090/0/ACTBudgetModel.XLS) to calculate the costs of implementing ACT.

The ultimate savings of tax dollars spent on mental health services would be to close the hospitals and then not provide services in the community, but the total cost to consumers, their families, and the community would be very expensive in so many other ways. The finding that ACT can only be cost justified if the consumers are being released from the hospital at the start of the study (Lewin Group, 2000) misses the point completely.

Assertive Community Treatment Fidelity

We have looked at clinical and cost outcomes. Program and system outcomes are examined under the heading of fidelity. ACT is very complex and no to programs are exactly alike, but what are the components of ACT implemented in most agencies. In a literature review of 303 ACT programs in 34 states Deci et al. (1995) found that

almost every program deviated from the original model to meet local system goals and to tailor the programs to their consumers. Table 5 presents the most common components of ACT used but not related to consumer outcomes.

Table 5
Commonalities Among 303 ACT Programs

Percentage of Programs	Service
71%	24 hour a day services
88%	Psychiatrist as team member
88%	Nurse as team member
55%	Direct provision of services to consumers (not brokered)
45%	Shared common case loads

(Deci et al., 1995)

Table 6 lists the components and operating practices of ACT programs correlated with positive consumer outcomes.

Table 6
ACT Program Components Related to Positive Consumer Outcomes

Community services (provided *in vivo*, not in the clinic)
Assertive engagement mechanisms
Small case loads, the team approach (shared case load)
Explicit admissions criteria

(Bond et al., 2001; Lewin Group, 2000)

Tables 5 and 6 with the description of ACT give a picture of what an ACT program should be, but there is little evidence about the contributions of the program

components to consumer outcomes (Lewin Group, 2000; Mueser et al., 1998). Another consistent finding in the research literature is that programs with the highest fidelity to ACT also have the most favorable outcomes (Bond et al., 2001).

The question becomes, how do the managers of a program know if it is operating with fidelity? There are at least four major models of fidelity (Lewin Group, 2000), and several fidelity scales have been developed based on expert opinion and tested on operating programs (Allness & Knoedler, 1998; CARF, 1999; McGrew & Bond, 1995; Teague, Bond & Drake, 1998; Teague, Drake & Ackerson, 1995;). The Dartmouth ACT Fidelity Scale (DACTS; Assertive community treatment implementation resource kit, 2003; see Appendix D) based on objective criteria was able to discriminate among programs (Teague, Bond & Drake, 1998). When the developers of the DACTS used a fidelity scale to rate program outcomes, the programs with the highest fidelity scores also had consumers with the fewest number of inpatient days and other positive outcomes (McGrew et al., 1994; Teague, Drake & Ackerson, 1995). Because ACT requires modification of the whole CRT program when implemented The General Organizational Index (GOI; Assertive community treatment implementation resource kit, 2003; see Appendix E) may also be used to examine the support for ACT at the mental health center.

Vermont Agencies Experiences Implementing Assertive Community Treatment

Northeast Kingdom Human Services.

In Vermont Northeast Kingdom Health Services (NEKHS) is the only mental health center that has ACT teams. These teams are located in Newport and St Johnsbury, and they have been in operation for six years. Shari Tessier, the ACT team

leader from Newport made a presentation about the ACT teams at NEKHS to the CPAP. The following are notes from her presentation that describe the implementation of ACT at NEKHS, and explain how the ACT principles have been followed with the main points summarized in Table 7.

One advantage NEKHS had from the start was a psychiatrist who had worked with ACT extensively before coming to NEKHS. She became the “champion” for ACT. Shari believes the program has been successful because In addition to a strong leader good passionate people are working to keep the PACT going.

Implementation of any practice is important, but ACT is more than a practice. ACT is a model for doing business and requires major organizational changes. Fortunately for NEKHS the ACT, DBT and case management light were all implemented at the same time, which was a complete overhaul of the structure of the CRT program. Implementation of changes that affected all of the CRT program at a single time contributed to the successful implementation of ACT.

The *PACT Model: A Manual for PACT Start-Up* (Allness, & Knoedler, 1998) developed by the National Alliance on Mental Illness (NAMI) has been used extensively as a guide to implementation and the continued manage the PACT teams. The staff use this manual daily to guide their practice and the manual helps to maintain fidelity.

The criteria for admission to the NEKHS PACT services includes a person who:

- Has a psychotic disorder (schizophrenia or schizoaffective disorder) or other disorders with psychotic features (e.g., bipolar disorder, depression), and requiring services more than one time per week.
- Is returning from the hospital and still being stable

A consumer who is in a crisis who meets the general criteria for the PACT team will receive services from the team until an assessment is completed when the consumer will either be retained in PACT services or step down to a lower level of service. It is important to note that PACT is not appropriate for people with Axis II personality disorders. Because the intensity of the daily contact with the PACT team staff is not conducive to positive outcomes these consumers, they are served by the DBT team.

About half the consumers admitted will remain with the team for the long term and the other half will stabilize and step down to a lower level of service. From the long term group some consumers do move from PACT team services to a lower level of service, but this is a slow process. Some consumers never respond to the PACT services.

A high percentage of the clients served who are under 40 years old have substance use problems. The frequency of contact with PACT clients means there is a good opportunity to work with the consumers on substance use issues. It may be a matter of persistence with ACT, because consumers over 40 tend to use substances much less frequently.

The assertive part of ACT is outreach. The outreach is very intensive at NEKHS. Team members will knock on a door till there is a response. “Persistence for Progress” It may seem pushy, but it works for some people. It may take 6 to 8 months to get a person to open the door. Strategies like brining groceries help doors open.

The PACT services aren’t 24-7 at NEKHS. The PACT teams are backed up by the emergency team evenings (10:00 PM to 8:30 AM) and weekends, but the PACT

teams also back up the emergency team at other times. For example, every work day one team member is designated as the emergency person for the day. These procedures are working, but the period from 2:00 PM to 10:00 PM is the most lonely period of the day, and it would help to have another person for emergencies during this period of the day.

PACT Services following the ACT model are primarily provided in the community, though some of the time is necessarily spent at the mental health center. The location in Newport that the PACT team occupies is disconnected from the main mental health center building. The space is not “clinic like”, which makes the environment more comfortable for the consumers. Another aspect of the PACT teams that improves the environment is the four former consumers on the team in Newport who work a total of 2.5 fulltime equivalents (FTE).

The team works as a group with all team members having full access to the client’s record. One team member is responsible for a client, but everyone on the team works with all clients. There is a logbook of contacts that allows the case manager to write notes. Because all team members have contact with all the clients, there is always a staff member available to the consumer with whom he/she has a relationship when a staff member departs from the team, which makes these transitions much easier. The team approach is not accepted by everyone in Vermont. At another mental health center the team approach is viewed as spreading the responsibility for a consumer’s welfare among too many people.

Other things that contribute to the PACT teams’ quality of service are the nurse on the team which has improved the quality of medication administration; the team

being able to follow some consumers into the hospital; and when the consumer consents the teams work with families, which is especially helpful for younger clients.

Table 7
Most important components of PACT at NEKMHS

- Shared caseloads allow for staff turnover and reduce crises, because the consumers know more than one staff member.
- The PACT team is able to work in cooperation with the emergency team.
- There is diversity of experience on the team (psychiatrist, nurse, employment specialist, peer, case managers).
- Clients make the schedule.
- The case loads are kept small.

Other mental health centers.

Services similar to ACT are provided at other mental health centers. The program in Lamoille County Mental Health (LCMH) is a hybrid program that incorporates some elements of ACT in the program. The services and principles employed are similar to ACT but the structure is different. For example, mostly due to the availability of staff a commitment to 24/7 service is a problematic, and there is medication monitoring only if it is recommended by the doctor. At the Counseling Service of Addison County (CSAC) there is one big team, because it is difficult to staff an ACT team, there needs to be a critical number of people who need high end services.

Resources Required for Effective Implementation of Assertive Community Treatment in Vermont

The three key issues associated with implementing ACT programs are:

- Staffing, including recruiting, training, and retaining the right mix and number of professionals and their peer counterparts on the team

- Financing, including obtaining the level and type of funding that support ACT programs. This includes finding ways to be paid for outreach and paying peer specialists a sufficient salary.
- Geography, including overcoming geographic barriers to staff and community-based service availability and consumer participation (Lewin Group, 2000).

Recommendations of the Clinical Practices Advisory Panel for the Evidence-based Practice Assertive Community Treatment to the Division of Mental Health June 1, 2007

> Assertive community treatment (ACT) is appropriate for individuals who experience the most intractable symptoms of severe mental illness and the greatest level of functional impairment. These individuals are often heavy users of inpatient psychiatric services, and they frequently have the poorest quality of life (Phillips, Burns, Edgar, et al., 2001).

This is a very good description of the client who should be included in an ACT program. The one addition is that ACT is not for clients who have an Axis II personality disorder diagnosis.

1. An agency should consider the implementation of an ACT program if the agency's clients have had a sustained high rate of hospital and emergency use.
2. Agencies should not be required to establish an ACT program, but agencies could choose to incorporate the principles of ACT into outreach programs. These principles described by Phillips, Burns, Edgar, et al. (2001) are.
    - Services are targeted to a specified group of individuals with severe mental illness.
    - Rather than brokering services, treatment, support, and rehabilitation services are provided directly by the assertive community treatment team.
    - Team members share responsibility for the individuals served by the team.
    - The staff-to-consumer ratio is small (approximately 1 to 10).
    - The range of treatment and services is comprehensive and flexible.
    - Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.
    - There is no arbitrary time limit on receiving services.
    - Treatment and support services are individualized.
    - Services are available on a 24-hour basis.
    - The team is assertive in engaging individuals in treatment and monitoring their progress.
3. There is a large impact on an agency when a program change to ACT is made, because ACT requires a complete change in program structure. It is advisable to make the conversion in the Community Rehabilitation and Treatment program at

one time. If an agency chooses to implement an ACT program, the State should provide the support for the complete reorganization.

4. Since ACT can appear to be coercive. Training should be offered on an ongoing schedule statewide by expert trainers on ethical standards and recovery principles, and the agencies should offer a program of supervision in these areas.

These are the Clinical Practices Advisory Panel's recommendations specific to ACT. There are also recommendations common to most practices included in Appendix Z of the report that are applicable to ACT.

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Appendix A
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Appendix B
Vermont Department of Mental Health
System Values
for Treatment and Recovery

Vermont Department of Mental Health System Values for Treatment and Recovery

Client Empowerment

Strength Based

Family Centered

Community Based

Least Restrictive

Non-stigmatizing

Recovery Oriented

Appendix C
National Consensus Statement on Mental Health

National Consensus Statement on Mental Health Recovery

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

PDF version
You will need Adobe Acrobat Reader to view this file.

Background

Recovery is cited, within Transforming Mental Health Care in America, Federal Action Agenda: First Steps, as the "single most important goal" for the mental health service delivery system.

To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings.

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

The 10 Fundamental Components of Recovery

Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey

and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear: Recovery is not a step-bystep process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). Th e process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront

them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefi ts individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefi ts of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Resources

http://www.samhsa.gov
National Mental Health Information Center
1-800-789-2647, 1-866-889-2647 (TDD)

Appendix D
Dartmouth Assertive Community Treatment Fidelity Scale

(Assertive community treatment implementation resource kit, 2003)

Assertive Community Treatment Fidelity Scale

Program________________ Respondent #____________________ Role__________ Interviewer____________ Date____________

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 less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.
H5	CONTINUITY OF STAFFING: 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.

Assertive Community Treatment Fidelity Scale

	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

	CRITERION	(1)	(2)	(3)	(4)	(5)
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.

Assertive Community Treatment Fidelity Scale

	CRITERION	RATINGS / ANCHORS (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.
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.

Assertive Community Treatment Fidelity Scale

CRITERION		RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)
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
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.

Assertive Community Treatment Fidelity Scale

CRITERION		RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)
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.
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.

Assertive Community Treatment Fidelity Scale

CRITERION		RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)
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 hospitalize for rehab. nor 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 E
General Organizational Index

(Assertive community treatment implementation resource kit, 2003)

General Organizational Index (GOI) Scale

	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 eligibility	>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: <u># clients receiving EBP</u> # 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: _______

GOI Scale (continued)

	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 non-standardized	Pervasive deficiencies in two of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness	Pervasive deficiencies in one of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness	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
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 annually	>80% of practitioners receive standardized training annually

GOI Scale (continued)

	1	2	3	4	5
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
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

	1	2	3	4	5
G11. **Quality Assurance** (QA). The agency has a QA Committee or implementation steering committee with an explicit plan to review the EBP, or components pogram, 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

Appendix F
Draft
Recommendations of the Clinical Practices Advisory Panel Common to Most Mental Health Practices

Draft
Recommendations of the Clinical Practices Advisory Panel
Common to Most Mental Health Practices to the Department of Mental Health
June 1, 2007

1 Agencies should be allowed to implement an evidence-based practice (EBP) over time, because implementation of any EBP is a process that may require significant changes in an agency.
2 All agencies should be required to follow the recovery values as defined by the Vermont system of care, and the State should provide training and other necessary resources to implement and maintain the agency's ability to follow these recovery values at all system levels from frontline staff through the management of the agencies.
3 All agencies in Vermont should offer recovery-based options to their clients participating in the Community Rehabilitation and Treatment (CRT) programs.
4 All agencies in Vermont should be encouraged to develop the peer leadership potential in their recovery programs. Designated agencies and the State should support the development and inclusion of peers and peer run programs as part of the system of care at the designated agencies and in the community. The support should include resources such as training and stipends for peers.
5 Not all clients are ready to participate in a recovery intervention. To avoid a failure experience clients' agencies are encouraged to assess the readiness of clients to participate.
6 Whenever the State expects (requires or mandates) agencies to implement and maintain a practice, fidelity to a practice, or recovery principles the State should be expected to provide the resources necessary to implement and maintain the practice. These resources include but are not limited to:

    Appropriate reimbursement structures
    Appropriate staffing patterns
    Initial and continuing training for professional staff and peers
    Appropriate supervision
    Training Materials
    State consultation team to support practice quality and outcome-driven fidelity systems
    Reimbursement for participation in the statewide consultation team
    Information technology supports (e.g., computer systems, programming, and system compatibility among agencies and the State)
    Quality improvement activities

Administrative assistance

Administrative support for a statewide lending library

7 Practices implemented at the designated agencies should be considered in the local system of care plan quality improvement process by the designated agencies, Department of Mental Health and across the Agency of Human Services.

8 Consistent Documentation Infrastructure improvements need to be developed that support standardized documentation applicable to multiple clinical programming within the designated system of care. The standardized documentation should include at a minimum screening, assessment, treatment planning, outcome measurement, and the reporting of clinical information.

9 Data elements need to be developed that can be used to monitor both individual client's progress, and when aggregated program-level performance. These elements can then be incorporated in the electronic medical records system when it is available.

10 The designated agencies and State should consider the implementation of treatment programming that is consistent across designated agency divisions based on best practices principles for the population served. This will not only make treatment available to more consumers, but also increase the ability of the designated agencies to maintain the quality of their practices especially at the smaller agencies.