Ten years of implementation: Assertive Community Treatment and Integrated Dual Disorder Treatment in a statewide system

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Abstract

The prevalence and seriousness of co-occurring mental health and substance use disorders are significant public health issues facing our communities. Individuals with co-occurring disorders have worse outcomes in important areas, including physical health, employment, incarceration, and housing, and are often more difficult to engage in effective treatment. Equally important, however, are the multiple examples of impressive recovery journeys for individuals with even the most severe co-occurring illnesses, often in collaboration with treatment providers who support that recovery. Implementation and sustainability of evidence-based practices, which are associated with improved outcomes in areas of hospitalization, incarceration, employment, and treatment engagement, is an individual recovery and policy imperative. Yet, the implementation of these complex practices involving multiple practitioners from different disciplines can be challenging for systems of care. Training, systemic changes, and fidelity monitoring can be components to enhance implementation. In one state, the implementation, support, and fidelity measurement of two multi-disciplinary practices for the treatment of co-disorders, Integrated Dual Disorder Treatment (IDDT) and Assertive Community Treatment (ACT), is studied. Iterative steps to implementation over a ten-year period are examined. Lessons learned for research, policy, and training of teams to assist people in achieving recovery are reviewed.

Keywords: evidence-based practice, fidelity to model, implementation, sustainability, outcome measurement, Integrated Dual Disorder Treatment, Assertive Community Treatment
1. Background

In the United States, approximately 10.4 million adults ages 18 and up, or 4.2% of the population, live with a serious mental illness (National Survey on Drug Use and Health, 2017a). These illnesses, which include but are not limited to major depression disorder, bipolar disorder, and schizophrenia, often impact people sooner than other chronic illnesses (Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013; Institute of Medicine, 2015), meaning mental illnesses carry a higher lifetime disability rate than any other health condition worldwide (Institute of Medicine, 2015). Over 20 million adults (7.5%) have a substance use disorder in a given year. Having a serious mental illness puts individuals at higher risk of co-occurring substance use disorder, and vice versa, meaning that 8.2 million individuals in the United States had both a substance use disorder and mental illness in 2016 (National Survey on Drug Use and Health, 2017b). Having a Co-Occurring Disorder (COD), or dual diagnosis, is the term that is used to describe individuals who have a mental illness in addition to substance use disorder. For those living with a mental illness, substance abuse is often associated with harmful and negative outcomes that impact the symptoms of the mental illness and are disruptive to many life domains (Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013). In comparison to those with a single diagnosis, individuals with co-occurring disorders experience much higher rates of violent behavior, suicidal ideation, completed suicide, and problems with physical health (Thornton et al., 2012). In addition, rates of homelessness, unemployment, criminal justice involvement, and hospitalization are higher for individuals with COD compared to their single-disordered counterparts (Mueser, Noordsy, Drake, & Fox, 2003). Finally, individuals with COD have lower rates of treatment engagement. Often individuals with the most complex illness needs and poorest outcomes have lower chances of engaging with a team of professionals to help them navigate recovery (Drake, O’Neal, & Wallach, 2008; Tyrer & Weaver, 2004; Warren, Stein, & Grella, 2007). Practices and programs, which can engage individuals with COD and support their goals and recovery, are needed to impact the trajectory of these two chronic health conditions.

Due to the prevalence of co-occurring mental illness with substance abuse disorders, developing Evidence-Based Practices (EBPs), which are associated with improvements outcomes mentioned above, is a critical role for the behavioral health system. Once practices are studied and their efficacy demonstrated, the implementation process can begin, which is a complex process establishing a way to measure implementation, train practitioners, and align policies with improved outcomes for individuals served. Since improved outcomes are associated with the implementation of all the components of a particular EBP, measurement of implementation via a validated fidelity measurement is a component of EBP development. Fidelity scales define an EBP, which can measure a specific practice implementation against a gold standard of care demonstrated in research settings to be associated with improved outcomes. These fidelity scales measure and determine the degree to which the implementation of the approach is being accurately reproduced. In addition, fidelity evaluations can point to important areas of training and policy changes to support ongoing improvements in fidelity. Yet, there is a need for balance in evidence-based practice implementation between practice integrity and local adaptation, and the need for consistent implementation measurement to assure sustainability (Ogden & Fixsen, 2014). The implementation of high fidelity EBP models is critical, yet this aspect of the science
of effective treatment provision is often given less attention by researchers. The process of getting science into the hands of practitioners and ultimately clients is a developing field onto itself of implementation science (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Ogden & Fixsen, 2014). The components that facilitate and create barriers for implementation, whether from a team or systems perspective, are important to understand and impact in order to get the best treatment to people with complex needs, including adults with COD.

1.1. Assertive Community Treatment

Assertive Community Treatment (ACT) is an EBP that has been studied and implemented since the 1970s. ACT is a multidisciplinary team-based approach, including doctors, nurses, social workers, psychologists, and often peer supporters in the care of individuals with serious mental illness, many of whom also have co-occurring substance use disorders. Its implementation was modeled in a response to large state psychiatric hospitals closing after many individuals were discharged in stable conditions, but quickly returned to the hospital after rapidly relapsing (Schroeder, 2018). Instead of allowing for the revolving door of repeated psychiatric hospitalization to continue, ACT was developed as a program of care to define the principles that underlie a treatment approach for discharging psychiatric patients back into the community and providing services that are established in natural living environments (Schroeder, 2018). ACT involves 24-hour availability for all behavioral health needs with a low caseload of 10:1 for intensive engagement and recovery services. It commits to assisting clients in healthcare, housing, and employment through the single point of responsibility of the ACT team. ACT teams have been implemented over the last 40 years in every state in the U.S., as well as many countries.

ACT has perhaps become the “most studied and well-articulated service model for providing community-based, comprehensive mental health services to adults with serious mental illnesses” (Henwood, Siantz, Hrouda, Innes-Gomberg, & Glimer, 2018, p. 133). More than 30 randomized control trials have evaluated the effectiveness of ACT, focusing on individuals living in the community with a pattern of frequent hospitalizations, extended periods of inpatient treatment, or homelessness. The results supported ACT as an effective treatment associated with stabilized housing in the community, reduced re-hospitalizations and homelessness, and reduced co-occurring disorder (COD) symptoms (Mueser, Deavers, Penn, & Cassisi, 2013).

In order to support ACT implementation, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed an implementation toolkit, as well as fidelity tool for ACT (Ogden & Fixsen, 2014). The Dartmouth Assertive Community Treatment Scale (DACTS) was developed by Teague, Bond, and Drake (1998) as a fidelity measurement tool to assess the reliability of ACT. DACTS includes 28 items that measure and assess organizational processes, team staffing, and services provided by ACT (Teague, Bond, and Drake, 1998). The DACTS is an effective measure, but also requires significant time and reviewer training to implement, which has created barriers for the regular measurement of ACT fidelity in many systems of care (Teague, Bond, and Drake, 1998).

1.2. Integrated Dual Disorder Treatment

Because the ACT model has demonstrated such effective outcomes for individuals with COD, Robert Drake and Kim Meuser developed Integrated Dual Disorder Treatment (IDDT) to specifically incorporate elements of treatment for co-occurring needs. IDDT is perhaps the most complex
EBP designed by SAMHSA. Similar to ACT, IDDT incorporates a full multidisciplinary team, as well as assertive outreach, stage-matched treatments, motivational interviewing, and family and community services in addition to individual services. Over the past decades, SAMHSA has developed a significant amount of resources that provide EBP approaches that are effective for various populations. IDDT provides additional components to support those who fall underneath severe mental illness and co-occurring substance use disorder of care and who typically receive care within state hospital, jail/prison, and emergency room settings (Mueser et al. 2003). Additionally, IDDT follows a multidisciplinary, consumer-driven approach. This approach is “staged”, meaning that the course of interventions follows various stages of change and dependent upon the consumer’s attitude towards the treatment, whether the consumer is engaged, persuaded, active, or avoiding relapse (Pringle, Grasso, Lederer, 2017).

Once the IDDT approach was recognized and published by SAMHSA as an EBP, a toolkit was developed to provide fidelity scales that measured 26 (12 organizational items and 14 IDDT specific treatment items) to the IDDT model, each on a 5-point Likert scale (McHugo et al., 2007). The scores of the 26 critical components are then averaged to produce a fidelity score, where a total mean score of 4.00 or greater indicates high fidelity, 3.00 – 4.00 moderate fidelity, and less than 3.00 indicating low fidelity or poor replication (2007). These fidelity measures determine the current and future need for implementation supports for teams. Lower individual item or total fidelity scores suggest that the site may need additional training or other interventions to reach a higher fidelity in the near future and to support sustainability (2007).

To date, research on large state-wide samples for IDDT implementation is limited. Harrison and colleagues (Harrison, Curtis, Cousins, & Spybrook 2017a; Harrison, Spybrook, Curtis, & Cousins, 2017b) conducted a descriptive analysis study that looked at a full sample of IDDT reviews throughout one state from 2006 and 2012. IDDT for this analysis was implemented throughout community mental health agencies in 2006. In this statewide review of implementation, a total of 68 teams were reviewed within the 7-year period and results determined that the percentage of teams implementing at a high rate of fidelity increased steadily over time (Harrison et al., 2017a). Additionally, it was determined that in each review, “treatment subscale means were higher than organizational subscale means, indicating that treatment items are more developed at baseline review, and remain higher throughout review cycles” (Harrison et al., 2017a, p. 363). Even though fidelity has been measured in large samples at this point, there is less research on the support required to achieve large-scale implementation.

1.3. Implementation steps

This article aims to review the iterations of fidelity measurement of ACT and IDDT in one state over a ten-year period. These steps, which included areas of fidelity monitoring, training, policy, and funding changes, can provide steps to guide other systems not only in the supports needed to implement ACT and IDDT, but other complex EBPs in the behavioral health arena.

2. Methods and Materials

As in many states, Michigan began implementation of ACT in the 1980s. IDDT was added with the help of a federal block grant in 2005. The implementation, training, and fidelity monitoring process has expanded over the subsequent years.
2.1. Sample

In the sample of ACT and IDDT teams in Michigan, the structure of public mental health services is generally organized along county lines. Each county has a community mental health authority with an independent board, who are responsible for care of youth and adults who meet the priority population of people with serious mental illness, intellectual/developmental disabilities, or youth with severe emotional disturbance. Often but not always, the services for individuals with substance use disorders are met by the same agency. Community Mental Health (CMH) organizations receive Medicaid dollars on a capitated per population basis, and in some cases have access to block grant or public act funds to serve individuals. In some rural areas of the lower and upper peninsulas, CMHs are organized across multiple counties as an affiliation. In the largest metropolitan area in the state, Detroit, community mental health services are split into several sections of the metro area, which all report to a central authority. CMH services are varied throughout the state into direct operated (services provided by the CMH itself) and services that are contracted to provider organizations, with more rural CMHs tending to be direct operated. In some cases, CMH services are the only behavioral health services available in the county.

As part of the contract and funding for each CMH, each county is required to have access to ACT services. In some cases where there is not enough population to justify an ACT team, CMHs will contract with a neighboring ACT provider to provide services for residents of that county.

In 2005 when IDDT implementation began, many of the ACT teams that were already serving a substantive population with a co-occurring substance use disorder added IDDT services to existing ACT teams, making them both ACT and IDDT teams. In addition to these specific evidence-based practices, ACT/IDDT teams often added other practices, including Individual Placement and Support (IPS) supported employment, Family (FPE), and Dialectical Behavioral Therapy (DBT).

2.2. ACT Fidelity Review Tool and Process

Fidelity to an evidence-based practice is the most direct way of assuring that the outcomes that were achieved in the model development can be replicated within the implementation of an individual team practice. Since the outcomes of high-fidelity ACT and IDDT include improvements in substance use, housing, hospitalization, incarceration, and housing status, measuring model fidelity is critical to supporting the recovery of individuals with COD in any system of care.

ACT fidelity has been measured in Michigan for many years using the DACTS fidelity tool. In 2010, Michigan’s Department of Health and Human Services (MDHHS) developed a state-specific ACT Field Guide (Michigan Department of Health and Human Services, 2010; Michigan Department of Health and Human Services, 2016). The Field Guide contained requirements of staff members (e.g. number of FTEs and credentials required for the team), service array (e.g. 24-hour availability, single point of responsibility for services), and a fidelity tool derived from the DACTS, but with several Michigan-specific items added. In 2014, the ACT Field Guide contained 85 individual items to be scored, split into two subscales. There were 38 items in areas including Organization (7 items), Agency Policy (6 items), Location (6 items), Staffing (6 items), Safety (4 items), Transportation (6 items), and Communication (3 items) that were specific to Michigan, 47 in areas including Staffing Composition (9 items), Team Functioning (11 items), Pro-
gram Policy (7 items), Assessment and Treatment Planning (4 items), Outreach and Continuity of Care (8 items), and Program Intensity (8 items) derived from the DACTS and Michigan specific items. All items were scored on either a 4 or 5-point Likert scale, and averaged for a total fidelity score of 1.00 – 5.00. In one important divergence from national standards, Michigan began requiring that a Certified Peer Support Specialist (CPSS) serve on all ACT teams along with a physician, nurse, and case manager(s), making it the first state to systematically incorporate peer services within ACT. This change in policy was measured in the Role of Consumer on the Team fidelity item, which reads:

**SC5. Role of Consumers on Team:**
How are consumers involved as assigned members of your ACT team?

A. Consumer(s) have no involvement in service provision in relation to the ACT program.

B. Consumer(s) work in non-direct service provision roles.

C. Consumer(s) fill consumer-specific service roles with respect to the ACT program (e.g. self-help).

D. Consumer(s) work in direct service provision roles with reduced responsibilities.

E. Consumer(s) are employed as certified peer specialists, or with professional status when other qualifiers are met.

Annual ACT fidelity reviews were specified as part of the contractual obligation between MDHHS and ACT providers. Reviews were completed using 2 trained reviewers, and took place over 1-2 days, depending upon the team complexity and caseload. Following reviews, ACT teams were issued a report with fidelity scores and recommendations. Depending upon the mean total score, or specific elements of the ACT contractual requirements which were out of compliance, plan of correction items were developed, with dates certain for responses from teams.

### 2.3. IDDT Fidelity Review Tool and Process

IDDT fidelity was measured, beginning in 2006, using the SAMHSA’s IDDT fidelity tool. This tool, with 26 individual items, includes 12 items measuring organizational components as part of the General Organizational Index, including organizational philosophy, assessment, treatment planning, outcome and process measurement, and consumer choice. The Treatment Subscale contained 14 IDDT specific items, including stage-matched interventions, liaising with self-help, pharmacological interventions, motivational interviewing, and presence of a full multi-disciplinary team. As with the ACT fidelity tool, each item is measured on a 5-point Likert scale, with mean scores for both subscales, as well as a total mean fidelity score.

In contract to the compliance driven fidelity review process for ACT, IDDT fidelity reviews were completed through a newly formed review team of individuals throughout the state, the Michigan Fidelity Assessment and Support Team (MiFAST). The MiFAST team consisted of practitioners including social workers, counselors, psychologists, peer specialists, and quality managers who had experience in IDDT implementation. The team completed training for two days with the Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE) on the administration of the IDDT fidelity tool. Following training, MiFAST reviewers shadowed at least two reviews in Ohio.
with SAMI CCOE reviewers before completing reviews in their own state.

Teams implementing IDDT were able to ask for a MiFAST review at any point in their implementation. The review was completed over a single day with 2-3 reviewers, one lead reviewer and 1-2 assistant reviewers. Following the review, a fidelity report was generated, which held review scores, strengths for each item, and recommendations for any item scoring below a 5 of maximum fidelity. Fidelity reports were structured to also contain a section for IDDT team work plan to allow the team to note items, which they had worked to improve between the initial and subsequent fidelity reviews. Upon completion, reports were shared with the team and instructions given related to reporting IDDT services to MDHHS. See Figure 1 for an example of a single item of the fidelity tool, which included work plan elements.

Figure 1: MiFAST IDDT Fidelity Report for G5: Individualized Treatment Plan (MiFAST, 2018)
Upon completion of the IDDT fidelity review, IDDT teams were eligible to apply a specific modifier to billing codes for IDDT services, indicating the services were co-occurring enhanced (HH) and evidence-based (TG). Reviews were recommended annually for teams in the first 3 years of implementation, up until they reached a total fidelity score of 4.00, and every two years thereafter. However, there was no contractual requirement to complete fidelity reviews, nor was there a corrective action plan or other compliance reports due to MDHHS following reviews.

2.4. Combined Fidelity Review Tool and Process

Between 2005-2015, several team-based practices for adults with serious mental illness were added to the repertoire of many CMHs across the state. These included Dialectical Behavioral Therapy (Rizvi et al., 78-80), Family PsychoEducation (Substance Abuse and Mental Health Services Administration, 2010), Supported Employment/Individual Placement and Support (Substance Abuse and Mental Health Services Administration, 2010), Permanent Supportive Housing (Substance Abuse and Mental Health Services Administration, 2010), Cognitive Enhancement Therapy (McGurk, 72-73), and Illness Management and Recovery (Substance Abuse and Mental Health Services Administration, 2010). Each of these practices included requirements for training, and most also required a fidelity review every 1-2 years. There was a sense of review fatigue amongst the field. There were also questions related to the nature of the reviews coming from the field. Some of these became related to the required number of reviews, the incentives or disincentives of review completion and required follow-up activities, and whether reviews were based upon a compliance model or a performance improvement model.

As a result, there was an effort to move fidelity reviews, in addition to follow-up consultation and training, to the MiFAST model when possible, and to consolidate fidelity tools and review processes when possible. Given the overlap between the practices and review tools of ACT and IDDT, the decision was made to combine both tools into a single review tool that could review teams implementing ACT and/or IDDT during the same review process. In 2016, this tool development was completed, resulting in a new tool which contained three subscales: The General Organizational Index (GOI) with 12 items, which is present in both the DACTS and the IDDT fidelity tool, the IDDT Treatment Index with 14 items, and the ACT Treatment Index, which contained 21 items from the DACTS in addition to 4 items from the Michigan ACT field guide that were not included in the DACTS. The resulting scale contained a total of 51 items and was flexible to the extent that is the team was implementing ACT only, the GOI and ACT Treatment Index would be used, if IDDT only the GOI and IDDT Treatment Index, and if both ACT and IDDT on the same team all three subscales. See Figure 2 for the cross-walk which incorporates the citation for each item in the combined ACT/IDDT fidelity tool.
### Figure 2: MiFAST ACT/IDDT Fidelity Tool Citation Cross-Walk (MiFAST, 2018)

#### Michigan Fidelity Assistance and Support Team

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Since there were existing ACT and IDDT reviewers, all reviewers who wished to be part of the new MiFAST review structure received a two-day training on evidence-based practices, IDDT and ACT specifically, research on the models and their development, and the process of completing fidelity reviews and working with teams thereafter for consultation and training. Following training, ACT/IDDT MiFAST reviewers completed two reviews shadowing a practice leader or fidelity trainer, and then were eligible to become assistant reviewers and then lead reviewers. The distinction between the two roles was that while assistant reviewers were responsible for all of the aspects of the review day, including interviews, medical record and policy reviews, and observations of team activities, lead reviewers had those responsibilities, in addition to coordination of the review activities with the ACT/IDDT team leader, and fidelity report development. Following report development, the MiFAST reviewers and the ACT/IDDT team would complete a phone consultation to review the report and decide on any resources, consultation or coaching, or training the team was interested in as follow-up. Like the previous MiFAST IDDT fidelity review process, reviews were completed in one day, and review reports were not tied to any corrective action plan.

2.5. Analysis

Without attention to fidelity on evidence-based practice implementation, fidelity can erode over time (Harrison et al., 2017, pg. 116). With regular fidelity monitoring, including IDDT as a complex evidence-based practice, a high percentage of teams will reach high fidelity (Harrison, Spybrook, Curtis & Cousins, 2017b). An important component of fidelity monitoring from a state or system’s perspective are the trends in implementation and fidelity. This is particularly important when a process has changed.

3. Results

3.1. Teams

Of the 77 CMHs in Michigan, there were 38 ACT only teams in 2018, 17 IDDT only teams, and 57 ACT/IDDT teams operating in the state. Of those teams, 36 completed MiFAST fidelity reviews using the new system between June 2016-December 2018,
8 as ACT only, 10 as IDDT only, and 18 with combined ACT and IDDT in one review. See Table 1 for teams as well as reviews completed.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Teams Implementing</th>
<th>Review Completed (2016-2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>38</td>
<td>8</td>
</tr>
<tr>
<td>IDDT</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>ACT and IDDT</td>
<td>57</td>
<td>18</td>
</tr>
</tbody>
</table>

A significant component of the program improvements also included training new peer reviewers for MiFAST. In the initial iteration, there were 7 MiFAST IDDT reviewers, and 6 reviewers for ACT services. With the combined process in 2017, 24 new and existing reviewers were trained as either assistant or lead reviewers for both ACT and IDDT practices. All 24 unique reviewers completed fidelity reviews as either lead or assistant reviewers between June 2017-December 2018.

4. Discussion

Individuals with complex and co-occurring illnesses or conditions are prevalent, and a leading cause of disability and distress worldwide. Having a COD places individuals at risk for poor outcomes in health, housing, employment, and criminal justice involvement. We have evidence-based practices that can impact those outcomes, but implementation is complex and time-consuming, and requires sustained effort and attention to model fidelity by an entire team. Simply put, without fidelity monitoring, we may say we are implementing an evidence-based practice, but there is no way to determine if that is accurate or not. If not, the outcomes associated with the practice may not be able to be achieved with a particular team.

In Michigan, fidelity for ACT and IDDT teams can be implemented in a single review completed on a single day. The fact that reviews can be completed in a single day for either/or ACT and IDDT, and the number of teams reviewed in a 18 month period following the combination of these review processes, supports the efficiency of the approach.

4.1. Shared Implementation

As important as fidelity monitoring is, it can also be an unreasonable demand on teams already serving acute and complex clients, and with a whole variety of quality, training, and administrative demands in place. For this reason, fidelity reviews can become one more task that teams are loath to complete. If this is added to a review process that is perceived as punishing by teams, or involves corrective action plans, or even potential loss of revenue, organizations will avoid the fidelity review process if they can, thus missing out on a key tool in effective practice implementation and process monitoring.

The MiFAST process contains two key components, which help address those barriers to fidelity monitoring. The first is a philosophical approach of “all carrot and no stick.” Fidelity reviews are available to teams upon demand, and reports provided to the teams without a corrective action
plan requirement or connection to contractual revenue or compliance. Completing a review allows teams to access consultation, training, and coaching free of charge based upon the review findings but does not require any of those activities. In this way, the fidelity review process is less likely to be perceived as negative, and more likely to be perceived as a peer review process with benefits to the team after.

4.2. Shared Fidelity Measurement

Even when a fidelity review process is helpful, and unlocks desired training and other resources, it still requires time and energy on the part of the entire team. The preparation for the review, the review itself, and follow-up on the report, developing a workplan, or attending trainings, all take time away from direct service. This may be an acceptable burden if teams are implementing a single evidence-based practice. However, many teams are implementing three or more practices within the team. If each requires a fidelity review, to be planned, executed, and followed-up on, the time begins to add up.

It was for this reason that the MiFAST team has consolidated review tools and processes where available. The feedback from teams completing the ACT and/or IDDT review in a single day has been positive in the time saved. Some teams have even added completion of the Trauma Informed Organization (Center for Substance Abuse Treatment, CSAT, 2014) tool during the same review day. There is the possibility to add further reviews during the same time period, although less likelihood that review tools would be combined further. It is the hope that MiFAST reviewers will also continue to be cross-training in fidelity monitoring or many practices. Since most reviewers are themselves practitioners implementing one or more evidence-based practices, they are acutely aware of the time dedicated to fidelity monitoring and process improvement, and the benefit of more efficient time spent when possible.

4.3. Limitations and Future Research

Although the descriptive nature of this study provides important insights into an efficient model of fidelity monitoring for two evidence-based practices for adults in community mental health settings, there are substantive limitations as well. Due to the recent nature of the transition to a combined fidelity review process, as well as changes in the number of items particularly for the ACT Treatment Index, a comparison of fidelity before the reviews to the review tool and process, and after, were not completed. Second, data on inter-rater reliability between reviewers was not possible given the low number of reviews completed per reviewer. This will be important in the future however, to ascertain if reviewer is significantly associated with fidelity scores, which would be problematic and cause for additional MiFAST reviewer training or coaching.

Finally, a limitation is the fidelity process itself. Fidelity to evidence-based practice models is essentially a proxy measure. When initial development of ACT and IDDT were completed, high fidelity was associated with improved outcomes. The field therefore assumes that correlation will continue to exist in subsequent implementations. However, without monitoring of outcomes achieved by the particular people served within an evidence-based practice, that is not assured. With this large sample, correlation studies between item, subscale, and total fidelity scores and outcomes for clients served in areas including homelessness, unemployment, hospitalization, arrest, and incarceration will provide more confidence going forward of the relationship between ACT/IDDT fidelity and outcomes. The goal of evidence-based practice im-
Implementation is to provide an assistive treatment resource for people with complex illnesses to pursue recovery and wellness in their own lives. Making sure our systems of care and fidelity monitoring support that goal is crucial in continuing to have evidence inform practice to enhance recovery.

Acknowledgements

As with all research, this would not be possible without the work and support of several partners. Chief among them, Mark Lowis, Alyson Rush, and Brenda Stoneburner have led statewide efforts to implement, train practitioners, and measure fidelity for ACT and IDDT throughout the state for many years. Members of the MiFAST team are not only practitioners throughout the state, but also lend their time and expertise to measure fidelity and assist other teams in implementation of evidence-based practices for adults with complex behavioral health conditions. And finally, ACT and IDDT team members, comprised of social workers, nurses, physicians, peers, and psychologists, and the partner individuals they serve do all of the heavy lifting of implementation of these complex practices as well as the work of recovery, which is never done but always worth the journey.

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