ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 22, 2016

To: Tamera Spradlin, ACT Clinical Coordinator

From: T.J. Eggsware, BSW, MA, LAC
Georgia Harris, MAEd
AHCCCS Fidelity Reviewers

Method

On October 25-26, 2016, T.J. Eggsware and Georgia Harris completed a review of the Southwest Network (SWN) San Tan clinic Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

Southwest Network staff provides services to adults through seven outpatient clinics, five of which have ACT teams. Per the agency website, services at the clinics include: psychiatric evaluations, substance abuse evaluations, crisis intervention, help with thoughts of suicide, medication, nursing, case management, rehabilitation and support, personal care and life skills development, employment rehabilitation and training, peer and family support, housing support, transportation assistance, and language services.

The individuals served through the agency are referred to as "members" so that term will be used in this report.

During the site visit, reviewers participated in the following:

- Observation of the team morning meeting on October 25, 2016;
- Individual interview with Clinical Coordinator (i.e., Team Leader), Substance Abuse Specialist (SAS), Peer Support Specialist (PSS), and Employment Specialist (ES);
- Group interview with six members;
- Charts were reviewed for ten members using the agency's electronic health records system;
- Review of the agency documents and resources, including: *ACT Admission Screening Tool* and *ACT EXIT Criteria Screening Tool* developed by the Regional Behavioral Health Authority (RBHA), SWN policy 12.1.10 *Ending an Episode of Care Children and Adults*, SWN *Lack of Contact Checklist*, SWN *Groups 2 Go* documents, and training transcripts for identified staff in the Vocational Specialist positions.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of

Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team shares service provision responsibilities; all members are served by the full team.
- The team is staffed with two Nurses, which allows for services to be provided in the community or office. The Nurses have assigned caseloads equal to other staff on the team, and they assist in completing annual paperwork for those members.
- The team maintains low admission, graduation and drop-out rates, ensuring consistency and continuity of care for members. Members are not forced to leave the team until they feel they are ready, and members are rarely closed due to lack of contact. Other than members who moved out of the area with referral, graduated, or transitioned to other ACT teams or specialty services, the full caseload was retained.
- The team reports involvement in all hospital discharges, maintaining a high level of contact with members who are hospitalized, coordinating with inpatient staff, and supporting members when they discharge.

The following are some areas that will benefit from focused quality improvement:

- Work with each member and their support network, educating them on the team's role in a hospital admission. Seek to build rapport and trust with members who elect to self-admit without informing the team.
- Hire a second SAS and ensure they are trained in stage-wise treatment approaches, interventions, and staff activities for co-occurring treatment. A second SAS should enable the team to increase the number of co-occurring treatment groups offered.
- Increase the intensity and frequency of services to members. Aim for the average frequency of face-to-face contacts to be four or more per week, and the average intensity of service to be two hours or more per week, per member. The team appears to be equipped to increase individualized contacts with members in order to support them in their communities.
- Ensure groups developed and facilitated by ACT staff are supported by research as outlined in the SAMHSA evidence based practice (EBP) of ACT. Group activities facilitated by the San Tan ACT staff often occur in the community, and some members indicated they enjoyed the group outings; however, the program should review the pros and cons of continuing to offer multiple groups, versus spending the time in one-to-one interactions with members in their communities. Work with members to identify activities in their communities that align with their interests, preferences, and recovery goals. Some members interviewed expressed their preference of increased individual contact with staff rather than group activities.
- Engage informal support networks of members (i.e., people not paid to support members, such as family, neighbor, friend, or whomever the member identifies as a support) and assist them in acquiring the knowledge, resources and skills needed to support members.
- Consider updating the agency website in order to utilize multimedia to outline ACT services offered.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (4)	The team serves 100 members with nine staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of approximately 11:1.	• See recommendation for H6, Staff Capacity.
H2	Team Approach	1 – 5 (5)	The team appears to primarily function with a shared caseload. During interviews, staff spoke of primary caseload assignments to complete annual paperwork requirements, but indicated staff serve all members on the team. For example, staff reports they offer to visit members if they live in an area if staff is travelling there for other duties. Based on ten records reviewed, 100% of members met with more than one staff over a two-week period.	
H3	Program Meeting	1 – 5 (5)	Per staff report, the program meeting is held four days a week, and all members are discussed at each meeting. The team Psychiatrist and Nurses attend all meetings. During the meeting observed, all members of the team were discussed. Conversation varied from member-to-member depending on their status, and topics included: medications, housing status, plans to engage in substance use treatment, plans to outreach members or their supports, and member employment or other social activities.	
H4	Practicing ACT Leader	1 – 5 (3)	Based on available information, it appears the Clinical Coordinator (CC) provides services routinely as backup, completing home visits and making contact with members at the clinic. The CC estimates her time providing direct services to members at around 20%, with some limitations due to her responsibilities as a CC. For example, the CC noted that she is responsible for the	• CC should provide direct services 50% of the time. Continue efforts to monitor and track CC direct services to members. Review CC administrative tasks to determine if any of those can be transitioned to other staff at the clinic or agency, allowing the CC more time to provide direct member services, to model

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			coordination of coverage and services of all staff on the team, and she is involved when member crises arise. Based on review of the CC's productivity report over a month period, the supervisor provides services about 11% of the time. There were four CC contacts with members over a month timeframe documented in ten member records reviewed, two which occurred in the office setting, and two in the community.	interventions, and support the team specialists.
H5	Continuity of Staffing	1 – 5 (4)	Based on data provided by the agency, nine staff left the team in the most recent two-year period, resulting in just under a 38% turnover rate. The turnover included three Nurses and two Housing Specialists (HS) who left the team.	• Continue efforts to hire and retain qualified staff, including working with administration to thoroughly vet candidates to ensure they are the best fit for the position and the demands of an ACT level of service.
H6	Staff Capacity	1 – 5 (4)	The team operated at approximately 80% of staff capacity over the year timeframe, with 27 total vacancies over a 12 month period, and a staff who was on leave for approximately two months per CC report. Two positions are vacant, the Independent Living Skills Specialist and the second SAS, which has been vacant for the entire 12 month timeframe.	• The agency should assess barriers to filling vacant positions. See also recommendation in H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 (5)	There is one full-time Psychiatrist assigned directly to the 100 member program. The prior Psychiatrist left the team the week before the review, but the current Psychiatrist joined the same week, allowing for overlapping coverage by the two Psychiatrists. Staff report the Psychiatrist attends team meetings, provides community-based services about five hours a week, and is accessible. The Psychiatrist is not the lead Psychiatrist at the clinic, and rarely meets with members who are not on the ACT team.	
H8	Nurse on Team	1 – 5 (5)	The team has two full-time Nurses assigned to the team. The CC reports both Nurses provide	

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			community-based services, usually with one Nurse remaining in the clinic while the other goes into the field. Nursing duties include: conducting home visits, taking members to Primary Care Physician (PCP) appointments, coordinating with medical health providers, and providing medication services (e.g., injections, medication observations and education) for members on the team. The Nurses have assigned caseloads equal to other staff on the team, and they assist in completing annual paperwork for those members. Although both Nurses work flex schedules of four ten hour days per week, staff report they are accessible, and attend morning meetings. Per report, neither Nurse is the lead Nurse at the clinic, nor do they meet with members from other teams at the clinic.	
H9	Substance Abuse Specialist on Team	1 – 5 (3)	The team has one SAS, who has been in the position since 2014. The SAS has experience working with individuals with dual diagnosis, primarily related to the stages of change model, motivational interviewing, and American Society of Addiction Medicine (ASAM) criteria.	• Fill the vacant SAS position. • Provide ongoing clinical supervision to SASs on a stage-wise approach to co-occurring treatment, including: engagement, persuasion, active treatment, and relapse prevention.
H10	Vocational Specialist on Team	1 – 5 (4)	The ACT team currently has two Vocational Specialists, identified as the ES and Rehabilitation Specialist (RS). Per CC report, the training of vocational staff includes quarterly meetings with RBHA staff, online trainings, and workshops. The agency provided training transcripts for the RS and ES. The RS has participated in vocational support-related trainings since 2008. However, the ES was previously the general ACT specialist on the team, and transitioned to her current position about six months before the review. The ES's training	• Ensure Vocational Specialist staff receives supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings. Examples of training focus areas include: engagement, job development and placement supports, benefits education, and follow-along supports.

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			transcript showed participation in about ten hours total of vocational-related trainings.	
H11	Program Size	1 – 5 (5)	The team is of sufficient size to provide coverage, with ten direct service staff.	
O1	Explicit Admission Criteria	1 – 5 (5)	Per staff report, members are generally referred from other teams at the clinic, other agencies, or through the RBHA. When there are openings, the CC recruits for possible referrals through the clinic. Members are screened for ACT, usually by the CC, using the *ACT Admission Screening Tool*, and that information is reviewed with the Psychiatrist who makes the final determination whether the member will be accepted. The CC reports no administrative pressure to accept members the team determined to be inappropriate for ACT.	
O2	Intake Rate	1 – 5 (5)	Per report, the peak intake rate in the six months prior to review was four members in May 2016, with the other months of April through September 2016, ranging from zero to two admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 (4)	Per staff report, no members currently see outside Psychiatrists for medications, all members in substance abuse treatment receive it through the team, and the team does not refer to outside providers for any other specialty service. The team primarily provides housing services. Based on morning meeting observation and records reviewed, staff frequently address independent living skills with members, including prompting for medications, budgeting, and cleaning of residences. However, some members live in residences where non-ACT staff provides services. These include 4% of members in residential treatment settings and 2% of members in Community Living Placements (CLP). Additionally, about 4% of members live in congregate group	• Work with members in supervised or staffed residences to transition to more independent settings with ACT staff support. • The agency should review training and supervision options to ensure staff designated with a specialty area receives monitoring, support, and supervision specific to their role. See recommendation for H10, Vocational Specialist on Team. Review the benefits of integrated and competitive employment versus WAT. • If certain types of counseling are consistently referred out to brokered agencies, consider adding, training, or supervising ACT staff so the team is

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			home settings. The team engages members to develop employment and rehabilitative goals, supports members to explore socialization programs, and provides employment support services to about 13% of members. However, other members receive vocational services through brokered providers for work adjustment training (WAT) programs. It does not appear that the team provides counseling/psychotherapy.	equipped to provide that service.
O4	Responsibility for Crisis Services	1 – 5 (5)	ACT staff reported that the team is available 24 hours a day, seven days a week for crisis support. The on-call phone is rotated on the team to ensure coverage, with the CC as backup. Every member is given the phone number to the team's on-call phone, and members rarely call the crisis line directly. Some staff interviewed reported having gone into the field occasionally after hours to support members.	
O5	Responsibility for Hospital Admissions	1 – 5 (3)	Two staff interviewed reported the ACT team is involved in about 60-65% of admissions. Based on review with the CC, the team was involved in approximately 60% of the ten most recent admissions. Some members elected to self-admit without informing the team, or were hospitalized following a period when they were not in contact with the team. When the team is involved in admissions, and the clinic is open, the member is usually assessed directly by the Psychiatrist or other ACT staff, who then relays information about the member to the Psychiatrist. The team coordinates the admission for members who are voluntary. After normal business hours, the on-call staff assists members with the admission. The team also completes applications for court-ordered evaluation (COE) or	• If certain members have a history of self-admitting without informing the team, focus efforts on outreach and relationship building. For example, work with each member and their support network to discuss how the team can support members in the community to avert, or to assist in a hospital admission, if the need should arise.

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			amendments to court-ordered treatment (COT) if members are determined to be in need of further evaluation or treatment in an inpatient setting, but are not voluntary.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	The team was involved in the ten most recent member psychiatric hospital discharges based on review with the CC. The CC reports staff meets with members and coordinates with inpatient Social Workers (SW) within 24 hours of admission, and maintains contact with the SW during the member's inpatient stay to formulate a discharge plan. Staff visit with the member within 24 hours of the team being informed of the admission, and maintains contact at least every 72 hours during the inpatient stay. The ACT team tries to facilitate doctor-to-doctor consultations between the inpatient and outpatient providers. After discharge, the team meets with members daily for the first five days, and facilitates an appointment with the team Psychiatrist within 72 hours.	
O7	Time-unlimited Services	1 – 5 (5)	Members are served on a time-unlimited basis. Two members graduated in the past 12 months, and another two to three are expected to graduate in the next 12 months. When a member is stepping down to a lower level of care (e.g., Supportive) the team can offer to co-case manage the member for a period during the transition, if it is determined to be of benefit to the individual.	
S1	Community-based Services	1 – 5 (4)	The Psychiatrist usually provides office-based services, going into the community about five hours a week. One member interviewed confirmed meeting with the Nurse in the community weekly for medication checks. One staff reported she spends about 50% of her time providing services to members in the community, and another staff	• The ACT team should increase community-based services to members, with the goal of 80% of contacts being made in the community versus the office setting. Prioritize individualized contacts with members in their communities, where staff can support them to connect with their

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			estimated about 80% of her time was spent providing services in the community. The rate of community-based services documented in ten member records reviewed showed a median of 61% of services occurred in the community. During the morning meeting observed, staff frequently mentioned plans to engage members in groups facilitated by ACT staff, which some members interviewed reported were helpful. Most members interviewed indicated they often meet with staff primarily in the office, or an even mix of office and the community. Only one member confirmed they primarily meet with staff in the community. When asked how the program could be improved, some members interviewed reported they wanted more individual time with staff versus group activities. It is not clear if groups facilitated by ACT staff limit their ability to provide a higher level of individualized community-based services to members.	natural supports, or identify resources, rather than recreating the clinic setting in the community. Group co-occurring treatment groups are part of the SAMHSA ACT EBP, but other groups facilitated by the ACT staff are not part of the model.
S2	No Drop-out Policy	1 – 5 (5)	Based on data provided for the year prior to review, 100% of the team caseload was retained. No members refused services, could not be located, closed due to the team determining they could not be served, or closed due to leaving the geographic area without referral. Other members who transitioned off the team for reasons not factored in this area include those who: graduated (2%), moved to other ACT teams (1%), or moved from the geographic area with referral (5%).	
S3	Assertive Engagement Mechanisms	1 – 5 (5)	The ACT team uses outreach and engagement mechanisms that include calls to: jails, last known numbers, family, emergency contacts, other friends, hospitals, and the morgue. For three members who remain homeless, staff reported the	

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			team outreaches by contacting shelters and visiting parks the members are known to visit. The team follows the agency *Lack of Contact Checklist,* which prompts for 12 weeks of outreach activities. The CC reported the team conducts two community-based and two phone contacts weekly when members lose contact with the team.	
S4	Intensity of Services	1 – 5 (3)	The median intensity of service per member was 58 minutes a week, based on review of ten member records. Three members averaged more than 100 minutes of service time per week over a month period, and a fourth member received just over 239 minutes. However, 87% of service minutes for those four members occurred in group settings. When asked how the program could be improved, some members interviewed clearly articulated they wanted more individual time with staff versus group activities.	• Increase the intensity of services to members, optimally averaging two hours a week or more of face-to-face contact for each member. Work with staff to identify and resolve barriers in increasing the average intensity of services to members. • Prioritize individualized contacts with members in their communities, where staff can support them to connect with their natural supports, or identify resources, rather than recreating the clinic setting in the community.
S5	Frequency of Contact	1 – 5 (3)	Ten member records were reviewed to determine the amount of times per week each member is receiving face-to-face contact. The average contacts per member per week ranged from one to just fewer than five, with two of ten members who received more than four contacts per week.	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support member goals.
S6	Work with Support System	1 – 5 (2)	One staff reported about 40% of all members have informal supports, and that staff have contact with informal supports for those members about weekly. Two other staff estimated about 50% and 92% of their primary caseloads had informal supports, and that someone from the team was in contact with those supports about weekly. Contact with informal supports or plans to outreach informal supports were infrequently	• Ensure ACT staff review with members the potential benefits of engagement with informal supports, and work to engage the supports in treatment, not only when people face challenges, but to celebrate success toward recovery. Work to educate informal supports to enhance their skills in supporting member recovery.

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			discussed in the team meeting observed, for about 12% of all members. The ten member records reviewed showed that the team had contact with informal supports for four of ten members, and for three of those members there was only one contact over a month timeframe, for an average of .5 contacts.	
S7	Individualized Substance Abuse Treatment	1 – 5 (3)	Of 50 members with a substance-use disorder, the SAS reported he meets with five to six people a day for structured individual treatment. The SAS reported he meets with members at their homes or clinic, discusses coping skills, and discusses the benefits of treatment related to the dual-diagnosis model. About 20 to 30 of the members with a substance-use disorder were identified to fall in the pre-contemplation stage of change, with about five to ten minutes of engagement occurring at each meeting. During the morning meeting observed the SAS reported he would meet with members to offer treatment, but those members with whom the SAS identified as receiving individual treatment were rarely referenced. It appears the primary focus of the contact is on engagement in group treatment. Documentation did not support that individual treatment was provided when the SAS had contact with members with substance use challenges.	• System partners should ensure ACT SASs are trained and receive ongoing supervision to provide individual substance abuse treatment. Hiring a second SAS should allow the SAS more time to provide individualized substance abuse treatment in addition to group treatment. • See also recommendations for S9, Co-occurring Disorders (Dual Disorders) Model.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	Per report, the SAS on the team facilitates one weekly hour long treatment group based on the agency's *Groups 2 Go* format, which draws from ASAM Criteria and SAMHSA Integrated Treatment for Co-Occurring Disorders, per the references cited in that material. Of the 50 members who face co-occurring challenges, about eight (16%)	• Increase the frequency of co-occurring treatment groups offered through the team. Consider aligning the focus of each co-occurring treatment group to accommodate members in different stages (e.g., persuasion, late persuasion, active

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			members attended group with the team in the last month. The group consists of a core group of about five members that attend consistently.	treatment, relapse prevention). Increase outreach efforts to encourage more member participation in co-occurring treatment. • See recommendations for S9, Co-occurring Disorders (Dual Disorders) Model.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (4)	Staff are familiar with the stages of change, but not a stage-wise approach to treatment. During the morning meeting staff occasionally noted what stage of change a member was in related to substance use, or other areas (e.g., employment). Stage of change language is also incorporated into service plans. The SAS was able to identify the stages of change, give some examples of interventions, including harm reduction activities, which he and the CC confirm the team favors over an abstinence focused approach. Staff provided recent examples of harm reduction efforts. The team may refer members to detoxification based on the discretion of the Psychiatrist, but this is rare per staff report. Some members are involved in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Members are informed about those meetings, but they are not the primary option offered; members are engaged in treatment through the team. Based on documentation, members with co-occurring challenges are offered the SA group, but infrequently offered individual treatment.	• Train staff in a stage-wise approach to treatment; interventions should be aligned with a member's stage of treatment. Train staff on the activities that align with member's stage of treatment and how to reflect that treatment language when documenting the service. This may better equip other ACT staff to engage members in individual and group treatment through the team. • Offer individualized treatment in addition to co-occurring disorder treatment groups. • If members elect to participate in AA, the team should work to educate them on the approach of that form of self-help group, including whether it is supported through research.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	The ACT team has a full-time PSS, with full professional status, who shares her lived experience. Members interviewed were familiar with the PSS and her role on the team.	
Total Score:		**4.11**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	4
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	3
6. Responsibility for Hospital Discharge Planning	1-5	5

7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.11**	
Highest Possible Score	**5**	