ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: March 6, 2015

To: Gary Pardo, CC

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ADHS Fidelity Reviewers

Method

On February, 11-12, 2015 Jeni Serrano and TJ Eggsware completed a review of the Bethany Village 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 provides adult behavioral health services that range from medication services only to assertive community treatment to the people of Maricopa County, Arizona. Services are provided at seven clinics, including two integrated health homes offering primary care services in coordination with behavioral health services. The Bethany Village location offers an assertive community treatment team primarily serving the young adult population of ages 18-25 years of age.

The individuals served through the agency are referred to as members.

During the site visit, reviewers participated in the following activities

- Observation of a daily ACT team meeting on February 11, 2015.
- Individual interview with team leader.
- Group interview with three members.
- Individual interviews with substance abuse specialist (SAS), transportation specialist (TS), and independent living skills specialist (ILS).
- Review of team admission and discharge criteria.
- Charts were reviewed for 10 members using the agency's electronic medical records system.
- Review of data related to staffing, staff turnover, as well as member admissions and discharges from the team.

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 primarily works with members 18-25 years of age.
- With the exception of recent turnover of four staff positions in November through December, 2014, the team maintains consistent staff over the twelve month period reviewed.
- The team provides time-unlimited services to members, with low intake and graduation rates.
- The team is actively involved in hospital admissions and discharges. Staff and the Team Leader are proactively involved in decisions to hospitalize, accompanying members to the hospital, visiting them during their stay and planning for their discharge.

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

Team Services and Contacts

- If primary caseloads are assigned for specific paperwork-related tasks, ensure the specialty staff are able to perform their specialist role as a primary function on the team. Preferably, staff would not have individual caseloads, but the team as a unit would be responsible for service provision to support members. Also, most ACT services should occur in the community.
    - On this ACT team, most services occur in the clinic rather than the community. In order to maximize community based services, the ACT team should review team processes requiring members or staff to be on site. For example, revise the team approach of providing only seven day bus passes to members rather than monthly bus passes if monthly bus passes, if available. This could be a way to reduce the amount of unnecessary contacts at the clinic.
    - The team specializes in working with members ages 18-25, but further targeted training through the provider, and with Regional Behavioral Health Authority (RBHA) support, is recommended. The team voices a desire for additional training to better serve the population of members in the target age range.
    - Although there may be contributing factors (e.g., recent turnover in staff), on this ACT team, many members do not meet with more than one staff over a two week period, and generally receive a lower than expected duration of service.
    - The team has an associated property where members of the team can reside. However, there are safety concerns at the residence. The agency should partner with housing management and the RBHA to resolve barriers to safely providing services to members at the property.

Practicing ACT Team Leader

- While the ACT team leader is committed to supporting the staff and providing members with a choice in treatment, the majority of the leader's responsibilities appear to be administrative. It is recommended that the ACT Team Leader spend at least 50% of the time providing direct services.

- If all identified administrative functions are required of the team leader, consider looking for other agency supports that could assist with some of these. Otherwise, this role and relative responsibilities may be an area of further review at the system level.
- The agency and system should explore all options to maximize team leader direct service time, allowing the team leader more time to mentor other staff in the community, as well as coordinate the development and provision of services to members.

Substance Abuse Treatment

- The team provides no direct individual substance use counseling or treatment, citing the SAS staff are not licensed. As a result, the nature of support focuses primarily on initial engagement, providing education, and then referring out to providers who are deemed qualified to provide substance use counseling and treatment. On the team, 49 out of 99 members are identified as having a co-occurring disorder, with only about six to eight of those members attending at least one substance use group during a month period.
  - At the Provider Network Organization (PNO) and RBHA level, explore training and educational options that could result in licensing and certification necessary to allow staff to provide individual counseling and substance abuse treatment.
  - Explore whether licensure is required to provide substance abuse treatment services, or if those services can be provided by a non-licensed staff member working under the supervision of a licensed professional. The RBHA should work with applicable oversight entities (e.g., Arizona Department of Health Services, Arizona Health Care Cost Containment System) to address barriers to ACT SAS staff provision of individual and group treatment in an integrated dual diagnosis treatment model. At the PNO and RBHA level, consider structural changes that integrate outside provider of individual counseling services as full-fledged members of the team. For example, ensure outside providers of co-occurring disorder treatment provide a written summary of progress and level of participation on at least a monthly basis for the member records, and explore options to integrate external providers into the ACT team. Preferably, the system will explore options to support ACT team staff in order to minimize or eliminate referrals to outside providers.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team consists of 10 staff members (excluding the psychiatrists) and provides services to 99 members with a member to team ratio of 10:1.	
H2	Team Approach	1 – 5 (3)	Over the two week period reviewed only 50% of members have face-to-face contact with more than one staff.	• Although members are generally in contact with at least one staff member consistently, the program should ensure services are delivered as a team. Training of all specialist staff should occur on a recurring basis to discuss current trends, interactions, and barriers to staff acting primarily as specialists on the ACT teams.
H3	Program Meeting	1 – 5 (5)	The team meets four days a week Tuesday through Friday as a full team to review each member of the team. On Mondays the team psychiatrist is off, so the team meets briefly to discuss the weekend crisis and updates.	
H4	Practicing ACT Leader	1 – 5 (2)	The ACT team leader conducts occasional hospital visits and face-to-face contacts as needed. The primary functions of the team leader are coordination and supervision of the staff and their activities with the members. Based on productivity reports, the amount of direct face-to-face clinical contacts for the ACT Team Leader is less than 2%.	• Review team leader administrative activities to determine if all are essential and required through the involved stakeholders or other oversight entities. • If all leader administrative activities are deemed essential, consider if there are other supports at the clinic that could assist in completing some or all of those tasks, which may allow the team leader to provide increased direct service to members. • If all identified administrative functions are required, team leader

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				responsibilities may be an area of further review to determine if action should occur at a system level. The need for this level of intervention cannot be fully confirmed at this time. • Ensure all Team Leader service activities are documented in the clinical records for the members served. • The agency and system can further support the team leader through training and specific guidance regarding organization and tracking of ACT services. Transitioning some tracking activities to the program assistant may free up time and allow the team leader to increase direct services to members.
H5	Continuity of Staffing	1 – 5 (3)	In the two years prior to review, ten staff transitioned off the team, resulting in a 42% turnover rate over the applicable two year timeframe.	• If not in place, conduct exit interviews with staff who resign in order to gather feedback regarding reasons for leaving, future positions, what management can do to maintain staff or to identify potential system barriers related to staff retention. • If not in place, conduct staff satisfaction surveys to gather information regarding why staff remain on the ACT team. The information may help in recruiting efforts for new ACT staff members who may be more likely to stay with the team.
H6	Staff Capacity	1 – 5 (5)	Although the team experiences turnover, positions are filled in a timely fashion, and as a result the team maintains consistent, multidisciplinary services by operating at 95% of full staffing	• Fill the Peer Support Specialist position and add two permanent nurses to the team.

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			capacity, in the past 12 months. The team recently lost the peer support specialist (PSS) and continues to fill nurse position with a traveling nurse (i.e., locum tenens).	
H7	Psychiatrist on Team	1 – 5 (5)	The team has 1 full-time psychiatrist who is 100% dedicated to the ACT team. The doctor may occasionally see members from other teams, but these activities do not constitute a significant amount of time. The psychiatrist works four days per week and attends morning meetings Tuesday through Friday. In addition to medication monitoring, the psychiatrist functions as a fully integrated team member, participating in treatment planning and rehabilitation efforts. The psychiatrist occasionally attends staffing at hospitals but refuses to do home visits in the community due to a past dangerous encounter while on home visit.	
H8	Nurse on Team	1 – 5 (3)	There is one full-time traveling nurse (i.e., locum tenens) 100% dedicated to the ACT team. The nurse may occasionally see members from other teams, but those activities do not constitute a significant amount of time. This team had multiple traveling nurses within the past 12 months, and the Clinical Coordinator (CC) reports traveling nurses are not permitted to go into the community to conduct home visits alone.	• Fidelity states best practice is for ACT teams to have at least 2 full-time nurses assigned per 100 members. Preferably, the nurses are permanently assigned to the team. Adding a second nurse allows flexibility to provide services to members. For example, the nurses can rotate coverage with one nurse remaining in the clinic, and one providing services in the field.
H9	Substance Abuse Specialist on Team	1 – 5 (3)	There are two identified SAS staff members on the team. Although both SAS staff have extensive experience in behavioral health and social services, one of the staff has less than 1 year of training or clinical experience in substance abuse	• Review training and supervision options to ensure staff designated with a substance abuse specialty receive monitoring, support and education in their role, for the population served.

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			treatment. One SAS has more than one year of training and experience. The extent of training and experience for the one SAS staff includes some training through the RHBA related to a curriculum in order to facilitate weekly groups.	Assure the designated SAS are providing co-occurring disorders specific individual and group counseling sessions.
H10	Vocational Specialist on Team	1 – 5 (1)	There are two staff in vocational roles on the team - an employment specialist (ES) and a rehabilitation specialist (RS). Neither specialist has training nor experience, other than what the PNO or RHBA provide. There is no evidence vocational staff emphasize skill development and support in natural settings, or that they are offering vocational services that enable members to find and keep jobs in integrated work settings.	• Fully integrated ACT teams include vocational services to assist members to find and keep jobs in integrated work settings. The team should identify potential barriers to directly providing vocational services versus referring to outside providers. • Review training and supervision options to ensure staff identified in the role of Vocational Specialists receive support, monitoring, and education in the role for the population served (i.e., adults diagnosed with a serious mental illness).
H11	Program Size	1 – 5 (5)	The team consists of 11 full-time equivalent staff.	
O1	Explicit Admission Criteria	1 – 5 (4)	The program serves a defined population; there is a written criteria in place. Referrals to the team generally come from the same clinic or others in the PNO. Additionally, this team specializes in serving young adults from age 18-25 years of age; however members over this age range have been accepted to this team. All members are screened, usually by the CC who coordinates with the referral source. The team psychiatrist usually makes the final decision to admit members to the team, but there are times when the team takes members as directed by the PNO. There are occasionally administrative lateral transfers of	• Preferably, the team makes the ultimate determination to admit members to the team based on application of a set criteria and consistent screening of all referred members. • The RBHA and agency should provide training and support to the team to enhance their ability to provide specialized services to the young adult population served. Ensure system partners are aware of this specialty team.

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			members already working with ACT.	
O2	Intake Rate	1 – 5 (5)	The team maintains a low intake rate, with four new members joining the team in October of 2014, three in August of 2014, two in November of 2014, and no new members July, September or December of 2014.	
O3	Full Responsibility for Treatment Services	1 – 5 (3)	Aside from case management, this team provides psychiatric services and housing support services, with less than 10% of members in residences where housing support services or overlapping case management occurs. The team refers out for counseling/psychotherapy, which includes individual and some group substance abuse treatment. Although the RS and ES may assist members with job search or with creating a resume, the ACT team refers to external providers for work adjustment or other supportive employment services. Staff are titled as specialists but have not been empowered to fill this role. Even though the ACT team is labeled as a team, the reviewers have concerns that the group generally functions more as a collection of staff members with individual caseloads, and specialists are not working on need basis but rather a rotation schedule.	• Members benefit when services are integrated into a single team, rather than when they are referred to many different service providers. Furthermore, an integrated approach allows services to be tailored to each member. In addition to case management services, this team needs to directly provide psychiatric services and medication management, counseling/ psychotherapy, housing support, substance abuse treatment, and employment/ rehabilitative services. • The RBHA and agency should provide training to current specialty staff so they can effectively provide interdisciplinary services to ACT members. The agency and system should review job descriptions to ensure they align with expectations of a fully functioning ACT team, so new hires come with prerequisite experience.
O4	Responsibility for Crisis Services	1 – 5 (5)	The team is primarily responsible for crisis services, available during weekday business hours, as well as on-call 24 hours a day, seven days a	

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			week. The CC meets with new members, discusses the role of the team during crisis, and provides the phone number for the on-call, the back up on-call, and CC phone.	
O5	Responsibility for Hospital Admissions	1 – 5 (4)	The ACT team is involved in 80% of admissions, with some self-admissions without team involvement, whether sought by members independently or with assistance from outside supports (e.g., family members). During office hours, members meet with the psychiatrist with effort made to prevent hospitalization.	• The RBHA needs to review system challenges to promptly informing ACT teams of member contacts with inpatient admission facilities. When teams are informed, they should meet with members to assess their status and discuss alternative supports (to address the presenting issue), or coordinate the admission. • ACT staff identifies one specific hospital where they have encountered challenges coordinating with the staff of the hospital. Since this report does not pertain to the hospital, the name is not included. It is recommended the RHBA work with the agency to discuss barriers coordinating with the hospital, and whether the pattern is pervasive. Further training with the hospital regarding notifying clinical teams upon ACT member admissions and discharges should occur.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	The team was involved in the hospital discharge planning of all ten of the most recent discharges. The staff is required to visit members in the hospital three times weekly. The staff members are required to contact the hospital social workers weekly and are required to be present at the hospital when a member is being discharged.	

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O7	Time-unlimited Services	1 – 5 (5)	The team experienced a 1% graduation rate in the past 12 months and anticipates five discharges due to graduation in the next twelve months.	
S1	Community-based Services	1 – 5 (2)	The team provides face-to-face service contacts in the community approximately 21% of the time, with a range of 0% to 100% community-based services over a month period for ten members. However, the members with 100% community-based contact received only one or two direct contacts over a month period. Most members receive below 50% community-based services. Community-based activities include attending mental health court with members, or brief home visit contacts, but most contacts occur in the clinic. The doctor and nurse do not provide services in the community without other staff.	• The team needs to work towards monitoring status and developing skills in natural community settings (where members live, work and interact with others), rather than functioning as an office-based program. • The team leader should monitor staff workload and time to ensure the majority of activities occur in the community. • Eliminate any agency policies/practices, in place that require staff to be at the clinic for specified hours each day to process paperwork or other administrative duties.
S2	No Drop-out Policy	1 - 5 (5)	Two members moved from the geographic area served by this ACT team without referral; however, in both cases the members reportedly left the country without informing the team they planned to not return. One member refused services, resulting in 99% of the team caseload retention over the 12 month period.	
S3	Assertive Engagement Mechanisms	1 – 5 (5)	The team demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms (e.g., probation/parole, outpatient commitment) or other techniques to ensure ongoing engagement. Outreach occurs weekly, and includes calls to family, hospitals, jails, probation or parole, as well as community outreach such as visits to local shelters. The team	

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			appears to have rapport with members; members seem to value the team, and note their ability to voice concerns, even if they don't always agree.	
S4	Intensity of Services	1 – 5 (2)	The median weekly face-to-face service time is 23.13 minutes per member per week. Many direct contacts with members are brief in duration.	• The RBHA and network should conduct time studies to identify barriers to staff providing increased direct services to members. A review of non-direct activities needs to occur to determine if all are essential to the functioning ACT team. • The team, network and RBHA need to review how direct service time with members can be increased. As the team continues to enhance services delivery through specialty positions, and continues to decrease reliance on outside providers, direct service time with members may increase. • Before referring to outside agencies, the team should carefully consider what service the external agency can offer that a fully functioning ACT team is not expected to provide.
S5	Frequency of Contact	1 – 5 (2)	Per interview report, weekly face-to-face contact is expected, with two home visits per month per member. Ten member records were reviewed to gather the actual number of face-to-face contacts with team members over a one-month period, from which the median number of weekly face-to-face contacts is derived. For those individuals, the median face-to-face contacts is 1.75, with less than two face-to-face contacts on average per week for seven members.	• The team seems to be unaware that the primary mission of an ACT team is to provide frequent, intense, community-based services to members. It is recommended that the agency and RBHA work with the team to identify and address barriers to the team providing member services in this manner. Review individual member needs that are not being addressed

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				through community-based services by ACT staff. Then develop a specific plan for whom will provide these services and when. • Review contact expectations to determine if the minimum of one face-to-face contact per member is adequate. This includes review of staff and possible system barriers to maintaining frequent face-to-face contact with members. • Team leader should periodically review member records and staff schedules to ensure appropriate face-to-face contacts are being made.
S6	Work with Support System	1 – 5 (3)	The record review captured very few informal support contacts initiated by staff. However, when asked, staff are able to easily identify the support network of some members on the team. It is estimated each member with support system in the community has 1-2 contacts per month.	• Continue efforts to coordinate with family or other supports. This includes check-ins with supports when members are doing well and when members experience challenges. These supports may include family, landlords, employers, or anyone else with whom members have consistent contact. Establishing communication may allow the team to provide education regarding serious mental illness, and to advocate for members. • For members who do not identify supports, continue to work with members to discuss the benefits of a support network, to identify supports the team is not aware of, and to discuss the potential benefits from

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				engagement of those supports.
S7	Individualized Substance Abuse Treatment	1 – 5 (2)	Although the ACT team includes two SAS staff, they do not have one year of training and/or professional experience in substance abuse treatment, and neither is licensed to provide substance abuse counseling or therapy. This is a reason that ACT staff cite for no formal individual substance abuse treatment for members by the team. Individual substance abuse counseling and psychotherapy are referred to outside providers. This team states the SAS staff does meet briefly one on one after weekly groups for check in.	• At the PNO and RBHA level, explore training and educational options that could result in licensing and certification for individual counseling and substance abuse treatment. The agency should collaborate with the RBHA to address barriers to ACT staff providing substance use treatment. • At the PNO and RBHA level, consider structural changes to integrate qualified outside providers of individual counseling services as full-fledged members of the team.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	The ACT team provides one co-occurring disorders treatment group per week. The ACT SAS uses a curriculum guide named *ACT Team Substance Abuse Group Curriculum.* This guide, created by the RBHA, provides general directions for conducting groups, including some activities, but it does not represent a formally- structured, meeting-by-meeting curriculum for an identified stage-wise approach. Approximately 6-8 of the team's 49 members with an identified co-occurring disorder attend at least one substance abuse group per month.	• Review the substance use treatment group's curriculum to ensure a co-occurring disorders treatment model is utilized. Several good manuals contain curriculum and strategies to engage clients in co-occurring stage-wise treatment groups. • Ensure staff facilitating co-occurring disorders treatment groups document and/or summarize member progress and level of participation in the member record at least on a monthly basis. Tracking member progress (or lack thereof) will help staff target their groups to members' specific needs.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	Staff that are identified in the role of SAS hold one substance use treatment focused groups per week, for one hour. Topics addressed may include barriers, stereotypes, mindfulness, relaxation, goal	• The provider and system should ensure ongoing and structured training is provided to all specialty staff, including integrated treatment for dual-

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			setting, and strategies to manage anxiety but may also be based on whatever topic the members want to discuss. There is report of referral to outpatient providers for substance use treatment, encouragement to attend AA, and team referral for detoxification services.	disorders. • For members with substance use challenges, the SAS should be a primary voice in driving team interventions for those members. Enhanced integrated dual-disorder training on a recurring basis may empower SAS staff across the system to intervene with members in a consistent manner, based on a proven model.
S10	Role of Consumers on Treatment Team	1 – 5 (1)	This position has just recently been vacant since 1/21/2015. For the 12 months prior, staff and members report the position was filled by a self-identified person with a lived experience of mental illness, and that person functioned as a full team member.	
Total Score:		**3.46**		

ACT FIDELITY SCALE SCORE SHEET

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

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	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	1
Total Score	**3.46**	
Highest Possible Score	**5**	