ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

Method

On November 14-15, 2017, T.J. Eggsware and Karen Voyer-Caravona completed a review of the Partners in Recovery (PIR) Metro Center Omega 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.

PIR operates seven outpatient treatment centers serving individuals with Serious Mental Illness (SMI), including: Metro, West Valley, Hassayampa, East Valley, Arrowhead, Gateway, and West Indian School. There are two ACT teams located at the Metro campus, Omega and Varsity. This report focuses on the PIR-Omega ACT team.

The individuals served through the agency are referred to as *clients*, *patients,* or *members*. For the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

During the site visit, reviewers participated in the following activities:

- Interview with the team Clinical Coordinator (i.e., Team Leader);
- Observation of a daily ACT team meeting on November 14, 2017;
- Two group interviews with a total of five members receiving ACT services;
- Individual interviews with a Substance Abuse Specialist (SAS), Nurse, and the Mental Health Specialist;
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of team documents, including: *ACT Eligibility Screening Tool* and *ACT EXIT Criteria Screening Tool d*eveloped by the Regional Behavioral Health Authority (RBHA)*;* resumes and training histories for SASs and Vocational staff; *ACT* brochure*;* 12 week outreach tracking form; *Omega Team Meeting* log*;* and PIR co-occurring treatment materials and resources.

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 is of sufficient size to provide necessary staffing diversity and coverage, maintaining a member-to-staff ratio of less than 10:1, and almost no extended position vacancies over the prior year. The team is staffed with a full-time Psychiatrist, and staff reported she collaborates with the team to determine treatment actions. Members interviewed spoke favorably of the Psychiatrist, noting that she takes time to listen to them, discusses their treatment options, and will adjust the course of treatment based on their feedback. Additionally, the team is staffed with two SASs, including one Licensed Independent Substance Abuse Counselor (LISAC), two Nurses, two vocational staff, and a person with lived experience (i.e., Peer Support Specialist).
- The ACT team meets four days a week to discuss each member of the team. During the team meeting observed, multiple staff contributed to discussions, were involved in planning services, and outlined their efforts to support members.
- The team provides crisis coverage to members 24 hours a day, seven days a week. The Psychiatrist and one Nurse are available for consultation after hours.
- The team maintains a low admission rate and based on staff report, no members closed due to refusal or terminating services, moving from the geographic area without referral, or due to the team determining the member could not be served.

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

- Other than substance use treatment groups, the team should evaluate the benefit of current clinic-based groups. Direct service contacts by ACT staff should occur primarily in the community and be focused on individual needs. Staff should facilitate any skills training in more natural settings where challenges are most likely to occur. For members who prefer group activities, determine if those can be fully transitioned to a community setting that best meets the member's identified recovery goals or where they have the opportunity to expand their support network and develop problem solving and other skills.
- Proactively engage members' natural supports on average four times monthly as partners in support of recovery goals. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports.
- Ensure treatment offered to members with co-occurring issues aligns with their stage of treatment. For example, evaluate whether disengaged members in earlier stages would benefit from developing rapport with SASs by shifting toward individual treatment before group treatment. Additionally, consider developing a group specifically for members in later stages of treatment. Treatment plans should reflect member goals; work with members to incorporate co-occurring treatment language into plans.
- Consider updating the agency website to outline ACT services offered, referral contact information for the ACT teams, and current clinic administrative contact information.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	Excluding the Psychiatrist, the member-to-staff ratio was just over 9:1 for the 103 member program. The team includes 12 full-time staff: Psychiatrist, Clinical Coordinator (CC), Employment Specialist (ES), Rehab Specialist (RS), Peer Support Specialist (PSS), Independent Living Skills (ILS) Specialist, Housing Specialist (HS), two Nurses, two SASs, and a Mental Health Specialist. The team also has access to a PIR float staff (titled Senior ACT Specialist), who provides services to ACT Omega members, but inconsistently due to providing coverage for other PIR ACT teams with vacancies. His time spent on this team was not factored into the member to staff ratio.	
H2	Team Approach	1 – 5 5	The member record review revealed that 90% of members had face-to-face contact with more than one staff member, in a two week period, which was higher than one staff member's estimate (80%). Members reported contact with multiple staff, though most frequently during visits at the clinic for groups or medication observations.	
H3	Program Meeting	1 – 5 5	Per staff report, the program meeting is held four days a week, all members are discussed at each meeting, and the team Psychiatrist attends at least two full meetings a week. The team members' schedules cover weekend hours and staff attend on the weekdays they are scheduled to work. During the meeting observed, there was evidence of staff taking the primary role in implementing services related to their specialty positions.	
H4	Practicing ACT Leader	1 – 5 3	The CC reported that she sees an average of 25 members a week, participates in hospital staffings, and has contact with members when they see the	• The CC should provide direct service to members with a goal of 50% of her overall time. Sharing in the provision of

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			Psychiatrist or Nurse. The CC estimated her time providing direct services to members at over 50%. This estimate was higher than information provided over a recent month timeframe that showed a total of 49 face-to-face contacts, which accounted for slightly less than 13% of her time. In ten member records reviewed, the four CC face-to-face contacts with members occurred in the office, but discussions with members ranged from review of a recent hospitalization to engagement to address substance use issues.	community-based services will allow for opportunities to observe, train, and mentor other staff.
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 about a 38% turnover rate. Multiple Nurses left the team during the two year timeframe, but most current staff have been with the team for more than a year.	• Continue efforts to retain experienced staff. When necessary, examine employees' motives for resignation, and attempt to identify causes for employee turnover. Optimally, turnover should be no greater than 20% over a two year period.
H6	Staff Capacity	1 – 5 5	There were no vacancies at the time of review. In the past 12 months, the ACT team operated at approximately 99% of full staffing capacity; one position was vacant for one month.	
H7	Psychiatrist on Team	1 – 5 5	The ACT team has one assigned Psychiatrist. The Psychiatrist works four, ten-hour days and attends ACT morning meetings at least two days a week. Although she is the Chief Psychiatrist for the clinic, staff reported her duties in that capacity or serving other team members occurs on a fifth day of the week outside of her 40 hours with the ACT team. Staff reported the Psychiatrist is available for consultation over the weekend, evening, and on the fifth weekday beyond the 40 hour workweek, when she sometimes meets with ACT Omega members. Members interviewed reported the Psychiatrist takes the time to listen to them, supporting them with a collaborative approach.	

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H8	Nurse on Team	1 – 5 5	The team currently has two Nurses. One nurse is primarily assigned to office-based duties, while a second Nurse primarily provides community-based services, focusing on members with ongoing medical concerns. The field Nurse reportedly frequently attends medical appointments with members and is available for consultation over the weekend and after-hours. The Nurses attend team morning meetings, do not have responsibilities outside of ACT duties, and rarely serve members from the other teams.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team has two SAS staff who have been in their positions for more than a year: an SAS and a Lead SAS who is a LISAC. Additionally, it was reported that the SASs receive weekly supervision in Integrated Dual Disorders Treatment (IDDT) and substance use treatment related interventions.	
H10	Vocational Specialist on Team	1 – 5 5	The ACT team currently has two Vocational Specialists who have been in their positions for more than a year, an ES and RS. Based on staff interviews and team meeting observation, the vocational staff assists members to explore competitive employment. However, based on training records provided, the staff received limited training related to vocational services (e.g., member benefits).	• Ensure both vocational staff receive ongoing training, guidance, and supervision related to vocational supports and best practices that aid members to obtain competitive positions.
H11	Program Size	1 – 5 5	The team is fully staffed, consisting of 12 full-time equivalent staff who provide direct services. The Senior ACT Specialist who covers ACT teams (when there are vacancies) was not factored into this item. There was limited verifiable evidence of services rendered by the float staff in ten member records reviewed, though he did attend the team meeting observed and participated in conversation for a small number of members.	

Item #	Item	Rating	Rating Rationale	Recommendations
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *ACT Eligibility Screening Tool* developed by the RBHA to assess potential admissions to the team. Staff confirmed they control admissions with no organizational pressures to admit members who the team feels do not meet ACT criteria. Per report, the team recruits from other teams at the clinic, for example using crisis contact tracking to identify potential ACT referrals, when the team has openings.	
O2	Intake Rate	1 – 5 5	The ACT team admission rate remained steady with three admissions per month in five of the past six months, and two in the sixth month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team provides substance abuse treatment, psychiatric care/medication monitoring, and most housing and employment services. Per staff report, no members receive brokered employment service provider support though staff reported some members work at other providers. In one record reviewed, a recent monthly summary for employment services was present; however, based on team meeting observation, it appears vocational staff assist members to explore competitive employment and during the meeting there were no other references of brokered employment service providers. Based on staff report and housing data provided, just under 10% of members are in staffed residences (e.g., residential, group homes or congregate living), excluding those in medical settings or through other systems of care. It does not appear the team provides counseling services, though a small number of members reportedly receive support from the campus Site Administrator, who is not a staff member of the ACT team.	• The team should be capable of directly providing individual supportive counseling psychotherapy (with the necessary clinical supervision and oversight) for members. • Work with members who reside in staffed residences to determine if other options are available where members can be supported fully by ACT staff.

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O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour crisis support. Members are provided with team phone numbers, including the on-call staff, and CC who serves as backup after-hours. Based on member records reviewed, there was evidence of services provided to members on evenings, and staff reported they go into the field, sometimes in the early morning hours or late evening, when needed. As noted earlier in the report, the Psychiatrist and a team Nurse are also available for consultation.	
O5	Responsibility for Hospital Admissions	1 – 5 4	During business hours, members can reach out to team specialists. Members can contact the team on-call staff after hours. Staff will attempt to deescalate the issue with the member and arrange for them to meet with the team Psychiatrist or Nurse the next weekday. If hospitalization is needed, staff accompany members and wait with them until admitted. When members are inpatient the team is in contact with inpatient staff (e.g., Social Workers and Psychiatrists) and meet with members every 72 hours. The team was involved in seven of the last ten psychiatric hospital admissions based on review with the CC; two members self-admitted and one was brought in by police.	• Discuss with members and identified supports (natural, etc.) the pros and cons of involving the team in issues that may lead to hospitalization; work to resolve barriers to team involvement. Increasing member engagement through more frequent and intense individualized provision of community-based services may afford ACT staff further opportunities to assess and provide interventions to reduce psychiatric hospitalizations and to build collaborative relationships with members' informal supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff reported the team is involved in all psychiatric hospital discharges. Members coordinate discharge plans, pick up members at discharge, and members meet with the team Psychiatrist within 72 hours, sometimes the day of discharge. Staff reported the team maintains face-to-face contact with members for five days post discharge, however in one record reviewed, documentation of face-to-face contact was not present for two of the first five days post discharge. The ACT team reported involvement in	• Coordinate with inpatient staff, members, and their supports (both informal/natural and formal) to reinforce the benefits of including the team in hospital discharges.

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			nine of the last ten hospital discharges. In the one instance where a member was discharged without ACT team being present or involved, staff reported the member declined team involvement.	
O7	Time-unlimited Services	1 – 5 4	Over the prior year nine members graduated from the team, and in the upcoming year staff projected the team will graduate seven members. The process includes updating the service plan to reflect the strategy to transition the member to a lower level of care (i.e., Supportive), including reducing ACT contact approximately 90 days prior to graduation. It was reported that the RBHA identified members across the system who may no longer require ACT services, and that teams were directed to consider those for graduation. However, staff reported it was important to retain members due to the extended timeframe it takes to build trusting working relationships. Some members interviewed reported staff discussed graduation with them, but they were hesitant due to the withdrawal of beneficial ACT support.	• The team should work toward maintaining an annual graduation rate of fewer than five percent of the total caseload. • As with admissions to the team, ensure ACT teams are empowered to work with members to determine whether they are appropriate for ACT services or ready for graduation.
S1	Community-based Services	1 – 5 2	Staff estimates ranged from 70-80% of their time is spent in the community. This was higher than the results of ten records reviewed, which found a median of 38% of all face-to-face contacts with members occurring in the community, and only one member who received more than 70% of service in the community. Multiple clinic-based groups are offered, and, as a result, many contacts with participating members occur in the office rather than the person's community, where staff can directly assess, monitor progress, model behaviors and assist members to use resources in a natural, non-clinical setting.	• Other than substance use treatment groups, which may be difficult to conduct in the community, the team should evaluate the benefit of current clinic-based groups. For members who prefer group activities, determine if those can be fully transitioned to occur in the community with team support or a setting that best meets the member's preference, possibly where they have the opportunity to expand their support network. Optimally, ACT services are delivered in the community where challenges are more likely to occur.

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S2	No Drop-out Policy	1 – 5 5	Members who left the team moved with referral (four), graduated (nine), or transitioned to other systems of care (one). Based on staff report, no members closed due to refusing services, could not be located, the team determined the member could not be served, or left the geographic area without referral. A *Navigator* system is in place, but to date no members have transitioned off the Omega ACT team to that status. Per report, staff were directed to transition members off the team to that classification after six weeks of no contact.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The team appears to have a process in place to monitor outreach to disengaged members. Staff reported they use a 12-week checklist to track outreach to members who are not in contact with the team. However, staff were directed to transition members off the team to the Navigator status after six weeks of no contact. If a member is not in contact with the team, staff may contact the payee to request a hold on a member's entitlement check until they contact the team. Staff reported about 50% of the members have payees.	• Reconcile whether the team's extended 12-week outreach process will be used over the briefer six-week of no contact before transitioning members off ACT teams to the Navigator status • Review the pros and cons of having payees hold checks for members until they make contact with the team. Explore alternative strategies, such as coordinating with payees for staff to be present at times when members are known to pick up checks.
S4	Intensity of Services	1 – 5 4	The median intensity of face-to-face service time spent per member was under 119 minutes based on review of ten member records. For some of those members, clinic-based group activities account for significant portions of their service time. For example, one member spent about 63% of service time in clinic-based group activities, and received fewer than 13% community-based services.	• The team should continue to work on increasing direct service time to members to at least two hours per week, on average.
S5	Frequency of Contact	1 – 5 4	The median weekly face-to-face contact for ten members was about 3.5 or under based on review of member records. It appears that members who	• Increase the frequency of contact with members by ACT staff to average four or more per week.

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			frequent the clinic for groups or who are asked to periodically check-in with staff have a higher frequency of face-to-face contact.	
S6	Work with Support System	1 – 5 3	The ACT team has infrequent contact with informal (i.e., natural) supports, more than once but less than two times, on average, per month. This frequency was consistent with one staff's estimate of one to two times per month. During the morning meeting observed, staff contact with informal supports, plans to contact, or involvement of those supports was referenced for about 16% of members.	• Encourage members to identify natural and supports and discuss with them the benefits of involvement in their treatment. • Document contacts with informal supports when they occur.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Based on staff reports, it was calculated that about 23 minutes of individual treatment is provided, on average, to members diagnosed with a co-occurring disorder. Staff reported individualized substance abuse treatment occurs once to twice a week for about 28-30 minutes to 22 of the 48 members diagnosed with a co-occurring disorder. Individual substance use treatment interactions were located in some applicable records reviewed, but generally appeared to occur about weekly when documented. It appeared both SASs provided individual treatment to at least one of the six applicable members with co-occurring issues based on ten member records reviewed. The duration and content of notes ranged from sparse information related to individual support to general case management duties, but other notes included more detail related to individual treatment.	• Review documentation of individual treatment during supervision with SASs to ensure services align with the members' stages of change and stage of treatment • Monitor member participation in individualized substance use treatment through the SASs to gauge duration and frequency.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The team currently offers three weekly co-occurring disorder treatment groups facilitated by SAS staff, two of which are held at the clinic and one that is held at a congregate living setting	• Consider revising the approach of how the three weekly groups are implemented. Rather than open to all members regardless of stage of treatment, consider

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			where a subset of ACT Omega members reside. Staff reported the groups focus more toward earlier stages of treatment, using Illness Management and Recovery (IMR) resources, due to many members assessed to be in earlier stages of change. Staff reported they adjust the focus of the group based on who attends on particular day or group; if members are in later stages of change then Recovery Life Skills materials are utilized. However, staff confirmed if members in later stages of change attend groups with members in earlier stages of change, the focus tends to remain on IMR materials. Some groups were blended, with topics related to specific diagnosis or taking medications effectively, and it appears they were open to members on the team who may not be identified as those with a co-occurring disorder. Staff estimated about 22-24 of the members with a co-occurring diagnosis attended a substance use treatment group over the course of a recent month. Based on available data and sign-in sheets, the reviewers were able to confirm that about 23% of the members identified with a co-occurring diagnosis participated in group treatment during a recent month timeframe. Evidence of co-occurring treatment groups was also documented in some of the applicable ten member records reviewed.	modifying so at least one group is structured for members in earlier stages, and at least one specific group is available for members in later stages of recovery. • The ACT team should engage members diagnosed with a co-occurring disorder to participate in treatment groups based on their stage of treatment. Optimally, at least 50% of dually-diagnosed members should attend at least one treatment group monthly.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The team approach to co-occurring treatment draws from Dartmouth Psychiatric Research Center (PRC) Hazelden resources including: *Integrated Dual Disorders Treatment (IDDT*), *IDDT Recovery Life Skills Program*, and *Illness Management and Recovery (IMR)*. Based on interviews and documentation reviewed it appears the team primarily uses a co-occurring treatment approach, with some exceptions. Regardless of	• Ensure all staff work from a harm reduction approach. The team would benefit from further review of harm reduction tactics and documentation, such as how to incorporate interventions in treatment plans and notes. • If wellness plans are developed with members, obtain copies for their treatment

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			stage of treatment, most applicable members were engaged to attend substance use treatment groups, though many members were assessed to be in earlier stages of treatment where individualized support may be more appropriate. Staff interviewed cited examples of harm reduction interventions. However, based on records reviewed, one staff regularly asked members if they were staying away from alcohol or other drugs, which indicates an abstinence focus. In treatment plans reviewed there was limited evidence that stage-wise treatment interventions were incorporated to support member goals. In some cases, it did not appear the member's goals were listed, but rather clinic team goals for members with common language focused on members gaining insight (e.g.," needs to gain insight into his mental illness and his substance abuse and needs to engage with his clinical team/mental health treatment"). Staff reported that wellness plans are developed with members, which the member is given in a folder with other treatment resources, but the plans are not filed in the member records. Some members elect to participate in self-help groups, and the team occasionally refers members for detoxification for medical reasons related to substance used.	files. Ensure phrasing in treatment plans align with wellness plans, written based off the member's words. • Obtain information about local self-help groups known to be welcoming to individuals with co-occurring needs so that if members seek that support staff are knowledgeable of available options.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has a full-time, fully-integrated Peer Support Specialist (PSS) with responsibilities equal to all the other team staff. Some members interviewed were familiar with the PSS and her role on the team.	
Total Score:		**4.36**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
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	5
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	5
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	4

6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	4
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	4
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.36**	
Highest Possible Score	**5**	