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**ASSERTIVE COMMUNITY
TREATMENT IN MAINE:
EVALUATING FIDELITY, SERVICE
USE AND OUTCOMES**

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Table of Contents

<i>Assertive Community Treatment</i>	3
<i>Methodology</i>	5
Introduction of Maine’s ACT Fidelity Review	5
Data Collection	5
Site Evaluators	5
Inter-Rater Reliability	6
Preliminary Reporting to ACT Teams	6
<i>Summary of Fidelity Findings</i>	6
Overall Fidelity Averages	6
ACT Implementation Domain Summary	7
Human Resources Domain.....	7
Organizational Boundaries Domain.....	10
Nature of Services Domain.....	12
<i>Results from ACT Services</i>	17
Preliminary Results	17
<i>Next Steps</i>	19
<i>Conclusion</i>	19
APPENDICES	21
ATTACHMENT 1-- ACT Fidelity Scale	22
ATTACHMENT 2—Letter to ACT Teams	27

Maine Assertive Community Treatment Team Fidelity Review

The Maine Department of Health and Human Services (DHHS) has developed an Evidence Based Practice (EBP) coordinating committee to promote the statewide development and implementation of evidence based and promising practices and guide the Department concerning the place of EBP in the delivery of behavioral health services. With support and guidance from the Department's EBP Coordinating Committee and Federal Data Infrastructure Grant, the Office of Quality Improvement collaborated with Office of Adult Mental Health Services to conduct a fidelity evaluation of the mental health Assertive Community Treatment (ACT) teams in Maine. The fidelity of an EBP treatment refers to the extent to which the delivery of the service is faithful to established practice standards. Since evidence based services are developed for specific groups of people and based on clear treatment guidelines, it is essential that the delivery of an evidence based service follow as closely as possible developed treatment guidelines in order to be effective and achieve desired outcomes. Therefore, an evaluation of fidelity examines the level of implementation of the evidence based treatment and the level to which service delivery is consistent with the established EBP treatment model.

Assertive Community Treatment

Using the Substance Abuse Mental Health Services Administration (SAMHSA) ACT Resource Implementation Kit, the Department's Office of Quality Improvement undertook a fidelity assessment during the Summer of 2006 of the ten ACT teams funded through Maine's DHHS. The ten ACT teams in Maine are as follows:

- Counseling Services, Inc (Springvale)
- Counseling Services, Inc (Saco)
- Catholic Charities Support and Recovery (Portland)
- Maine Medical Access (Portland)
- Maine Medical Diversion (Portland)
- Sweetser, Inc (Bath)
- HealthReach, Inc (Augusta)
- Tri-County Mental Health Services Hope (Lewiston)
- Tri-County Mental Health Services ACT (Lewiston)
- Community Counseling and Health Services, Inc (Bangor)

Assertive Community Treatment has been extensively studied and shown to be an effective treatment for adults experiencing serious and persistent mental health challenges. Recent studies conducted by the Dartmouth Psychiatric Research Center have identified key attributes of the ACT approach that contribute to improvements in a number of consumer outcomes. Those outcomes include: 1) reducing psychiatric hospitalization, 2) increasing housing stability and, 3) improving consumers' quality of life. Dartmouth's studies led to the development of a fidelity assessment tool; the Dartmouth Assertive Community Treatment Scale (Teague, Bond and Drake, 1998) (See Attachment 1) and informed the development of the SAMHSA ACT Implementation Resource Tool Kit. The SAMHSA tool kit along with the Dartmouth Assertive Community Treatment Scale served as a primary resource and guide to the Maine ACT Fidelity Evaluation.

The Dartmouth Assertive Community Treatment Scale contains 28 items that are divided into three fidelity domain areas to evaluate how closely a particular ACT team's structure and service delivery approach corresponds to the prescribed ACT treatment guidelines. Table 1 outlines the three fidelity domains of the ACT Fidelity Scale and describes the operational and service delivery elements that are measured in each domain.

Table 1: Assertive Community Treatment Fidelity Domain Areas		
ACT Fidelity Domain	Definition of Domain	What is Domain Measuring
Human Resources	Refers to the number and mix of professionals on ACT teams and the extent to which ACT teams use a multi-disciplinary approach to service delivery.	<ul style="list-style-type: none"> *Use of a multi-disciplinary team *Shared caseload *Low consumer to staff ratio
Organizational Boundaries	Refers to the structure and operations of ACT teams and the extent teams formally interact with other providers and organizations in service delivery.	<ul style="list-style-type: none"> *24-hour staff availability *Direct provision of all services by the team rather than referring consumers to other agencies *Time-unlimited services
Nature of Services	Refers to the way services are actually delivered to recipients of ACT services. .	<ul style="list-style-type: none"> *Providing services in the community, including developing and maintaining community support *Frequent contact with consumer *Dual disorder treatment

Methodology

Introduction of Maine's ACT Fidelity Review

The Office of Adult Mental Health Services, in collaboration with the Office of Quality Improvement, sent a letter to agencies providing ACT services describing the fidelity review process. Representatives from both offices met with each ACT team to review the methodology and expectations of the evaluation. (See Attachment 2)

Data Collection

The Dartmouth fidelity scale, as part of the SAMHSA ACT Implementation Resource Kit "Using Fidelity Scales for Evidence-Based Practices," was used as a guide for the Maine's fidelity evaluation. Site visits of 3-5 days were conducted with each ACT Team. Information was collected through structured interviews with multiple informants as well as selected record reviews. Site visit data collection included:

- Interviews with 10 individuals receiving services
- Interview with the Team Leader
- Interview with the Substance Abuse Counselor
- Interview with the Psychiatrist or another clinician
- Document reviews of 10 individuals receiving services
- Document review of ACT team meetings

Site Evaluators

A total of ten individuals representing the DHHS Office of Quality Improvement, the DHHS Office of Adult Mental Health Services and Advocacy Initiatives Network of Maine served as evaluators for the Maine ACT Fidelity Review.

The Office of Quality Improvement provided approximately 40 hours of training to all site evaluators from January to April of 2006. Training included a review of ACT principles, review and practice with the ACT tool kit protocols, interviewing techniques and data collection procedures.

Inter-Rater Reliability

The data collection methodology included ongoing monitoring of inter-rater reliability to increase confidence and minimize subjectivity of fidelity ratings. Evaluators worked in teams of two with each evaluator assigning a fidelity rating based on the information obtained. Upon arriving at fidelity ratings for each item, the two evaluators compared scores and determined an agreed fidelity rating based on the evidence obtained during the site visit. Evaluators resolved differences by jointly reviewing evidence obtained from the evaluation. Evaluators were instructed to contact the evaluation lead in the Office of Quality Improvement in the event that they were unable to resolve scoring differences.

Preliminary Reporting to ACT Teams

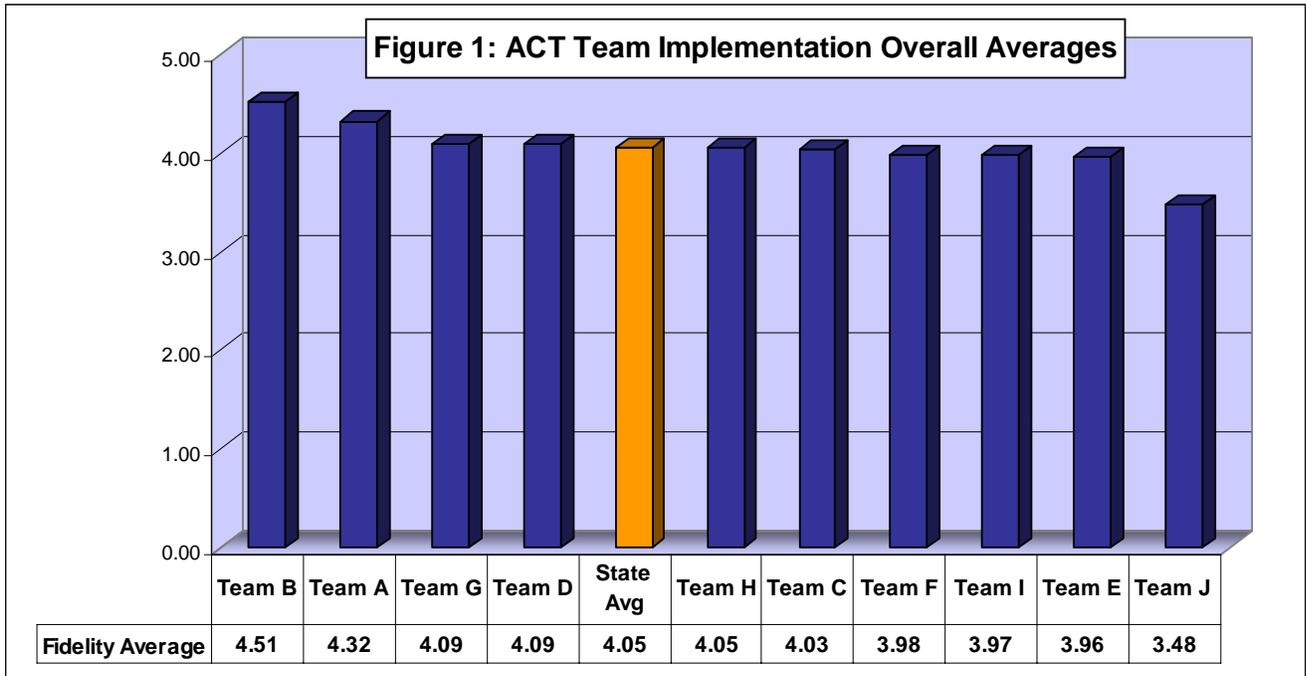
In August 2006 a representative of the Office of Quality Improvement and Office of Adult Mental Health Services met with the each ACT team to review the preliminary fidelity ratings. Each ACT team was presented with their ACT team scores and how they compared to the statewide average for each fidelity domain. ACT Team representatives were asked to assist in the interpretation of the findings, challenge principles of the ACT model and identify possible data limitations. Minutes of the dialogue were drafted by the Office of Quality Improvement and sent back to each of the ACT team for review and final editing. The minutes of these conversations are attached and have had final approval from each ACT team.

Summary of Fidelity Findings

Overall Fidelity Averages

Overall, the review of ACT Teams in Maine indicated a moderately high level of implementation to the requirements of the ACT model, yielding a statewide average score of 4.05 out of a maximum of 5 points (1 being the lowest level of implementation and 5 being the highest level of implementation).

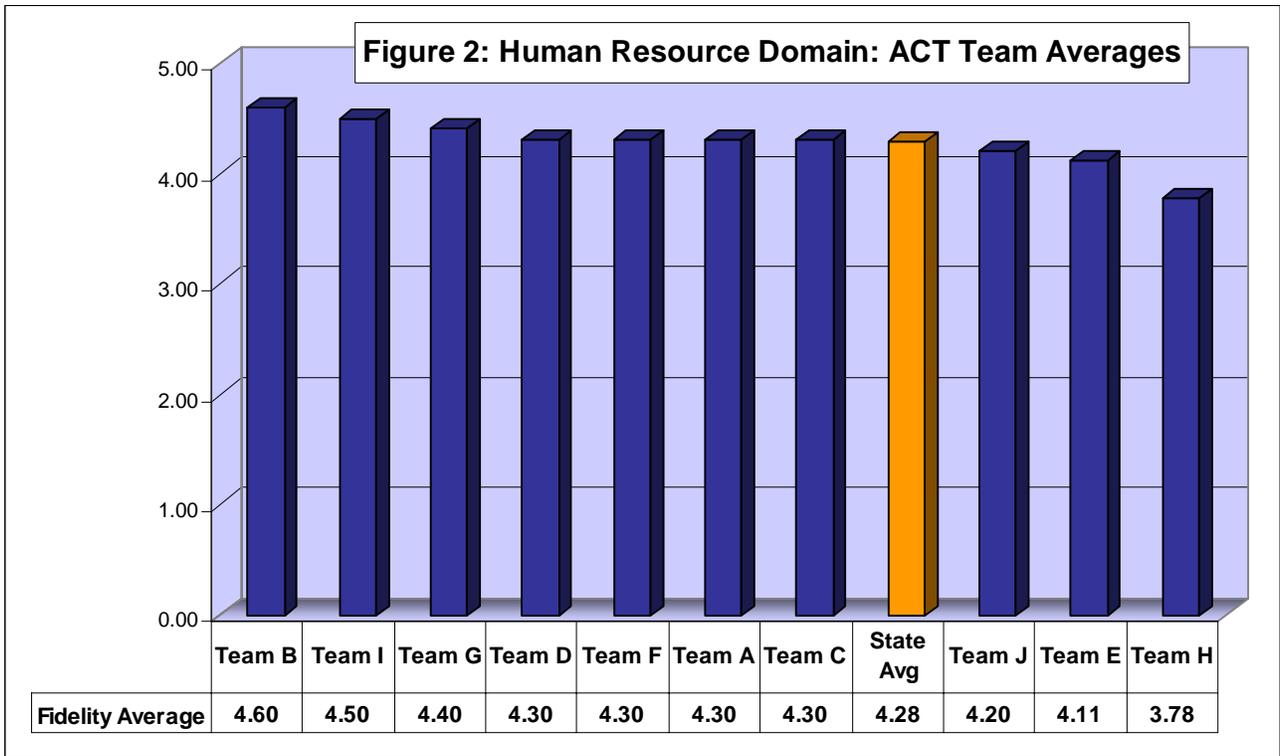
Overall implementation scores for individual ACT teams ranged from 3.48 to 4.51 showing variation across individual teams in their respective correspondence with the ACT treatment model. (*Figure 1*)



ACT Implementation Domain Summary

Human Resources Domain

The Human Resources Domain measures the number and mix of professionals comprising ACT teams and the extent to which ACT teams use a multi-disciplinary approach to service delivery. Individual ACT teams showed relatively strong adherence to the implementation requirements associated with the Human Resources domain with an average rating of 4.28. As shown in Figure 2, individual ACT teams scores ranged from a low of 3.78 to a high of 4.6.



The Human Resources Domain contains six implementation items. Table 2, lists the statewide average for each of the six items. The results show that Maine ACT teams generally meet national guidelines for implementation in the Human Resources area.

Table 2: Human Resources Domain Items	State Average Implementation Scores
H1: Small Caseload: Client/provider ration of 10:1	5
H2: Team Approach: Provider group functions as team rather than as individual practitioners; clinicians know and work with all ACT recipients.	4.5
H3: Program Meeting: Program meets frequently to plan and review services for each client	4.1
H4: Practicing Team Leader: Supervisor of front line clinicians provides and direct services	2.5
H5: Continuity of Staffing: Program maintains same staffing over time.	4.25
H6: Staff Capacity: Program operates at full staffing.	4
H7: Psychiatrist on Staff: There is at least one full-time psychiatrist per 100 individuals assigned to work with the program	4.6
H8: Nurse on Staff: There are at least two full-time nurses assigned to work with a 100-individual program.	5
H9: Substance Abuse Specialist on Staff: A 100-individual program includes at least two staff members with 1 year of training or clinical experience in substance abuse treatment	4.6
H10: Vocational Specialist on Staff: The program includes at least two staff members with 1 year training/experience in vocational rehabilitation and support.	4.3
Domain Average	4.28

Areas of Strength: Aside from item H4: Practicing Team Leader, all items in this domain received statewide implementation scores in the 4-5 point range, indicating that teams have adequate personnel and clinical staff to provide a multi-disciplinary ACT service and maintain appropriate consumer to staff ratios.

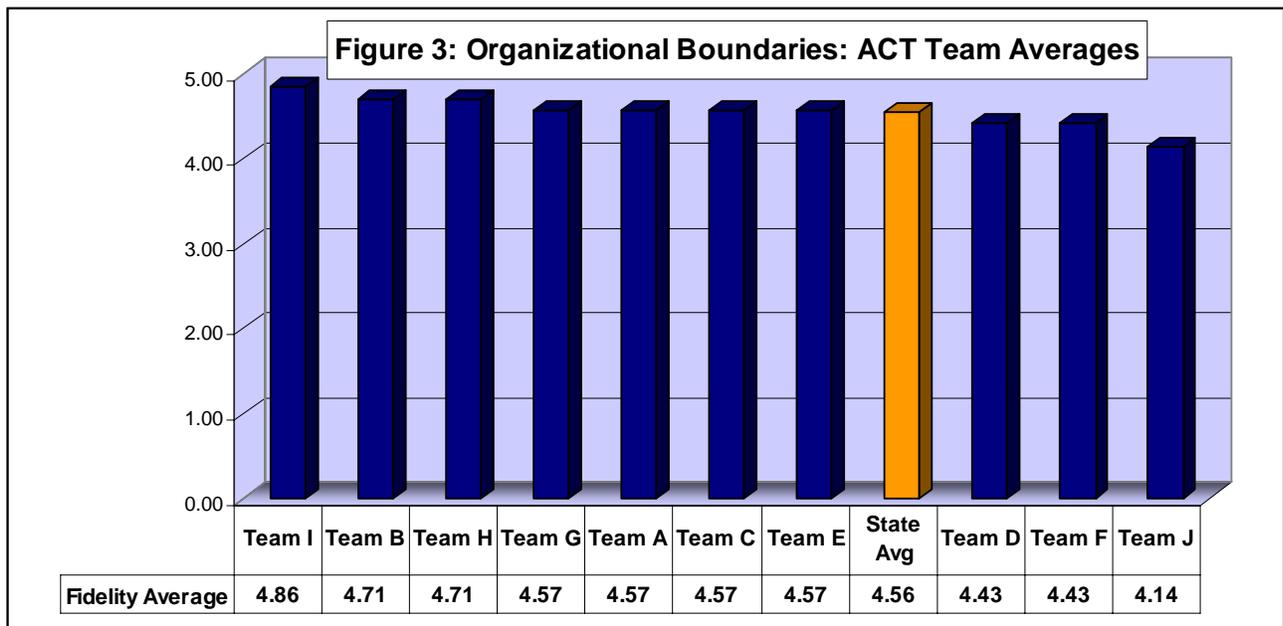
Area of Need: Item H4: Practicing Team Leader received the lowest statewide implementation score in the Human Resource domain with a 2.5. National implementation standards call for the supervisor or practicing team leader to provide direct services at least 50% of the time. A 2.5 score on the fidelity scale implies that team leaders provide direct services as back up or less than 25% of the time. In discussions with the Maine ACT teams, they attribute the lower score to one or more of the following factors:

- a) Inconsistent documentation of direct service contact with ACT consumers by Team Leaders. Some ACT teams reported lack of clear documentation guidelines to include contact with ACT recipients by ACT Team Leaders,
- b) Vacancies in the ACT Team Leader position during the fidelity review period; and
- c) Sharing of ACT Team Leaders within an agency having more than one ACT team.

Organizational Boundaries Domain

The Organizational Boundaries Domain examines the structure and operations of ACT teams and the extent to which teams coordinate with other organizations involved in delivery of services to ACT recipients. For example, are ACT teams involved in hospital inpatient admissions, discharges and after hours crisis intervention? As a group, the Maine ACT Teams demonstrated strong compliance to the expectations and requirements in this domain with an average statewide rating of 4.56.

As shown in Figure 3, individual teams received uniformly high ratings on this domain with scores ranging 4.14 to 4.86.



The Organizational Boundaries Domain contains seven items. Table 3 lists the statewide average for each implementation item. Again, the statewide results show a high level of correspondence to ACT implementation standards and expectations for this area.

Table 3: Organizational Boundaries Domain Items	State Average Fidelity Scores
O1: Explicit Admission Criteria: Program has clearly identified mission to serve a particular population and uses measurable and operationally defined criteria to screen out inappropriate referrals.	4.6
O2: Intake Rate: Program takes individuals in at a low rate to maintain a stable service environment.	5
O3: Full Responsibility for Treatment Services: In addition to case management, program directly provides psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.	4.6
O4: Responsibility for Crisis Services: Program has 24-hour responsibility for covering psychiatric crises.	4.9
O5: Responsibility for Hospital Admissions: Program is involved in hospital admissions.	4
O6: Responsibility for Hospital Discharge Planning: Program is involved in planning for hospital discharges.	4.7
O7: Time-Unlimited Services (Graduation Rate): Program rarely closes cases but remains the point of contact for all individuals as needed.	4.1
State Average Organization Boundaries	4.56

Areas of Strength: A key principle of the ACT model is direct provision of all treatment and support services by the team, rather than referring individuals to other agencies. Item O3: Full Responsibility for Treatment Services specifically measures this principle. It determines if, in addition to case management, teams directly provide psychiatric services, housing support, counseling/psychotherapy, substance abuse treatment, and employment/rehabilitative services. Evaluation of this item required reviewers to depend upon documentation within individual case files over a four-week period. Reviewers examined the content and nature of contacts, as well as which member of the ACT team made each contact

The ACT teams scored uniformly high on this item with an average statewide implementation rating of 4.6. Table 4, illustrates that seven of the ten ACT teams received a rating of 5, or were indicating full implementation. Two teams were found to provide three or four of the five additional services and referred recipients to outside providers, while one team provided two of the five services and referred recipients out for others.

Table 4: Full Responsibility for Treatment Services by Individual ACT Team

Domain	Team	State Avg									
Item	A	B	C	D	E	F	G	H	I	J	
O3	5	5	5	5	4	4	5	5	5	3	4.6

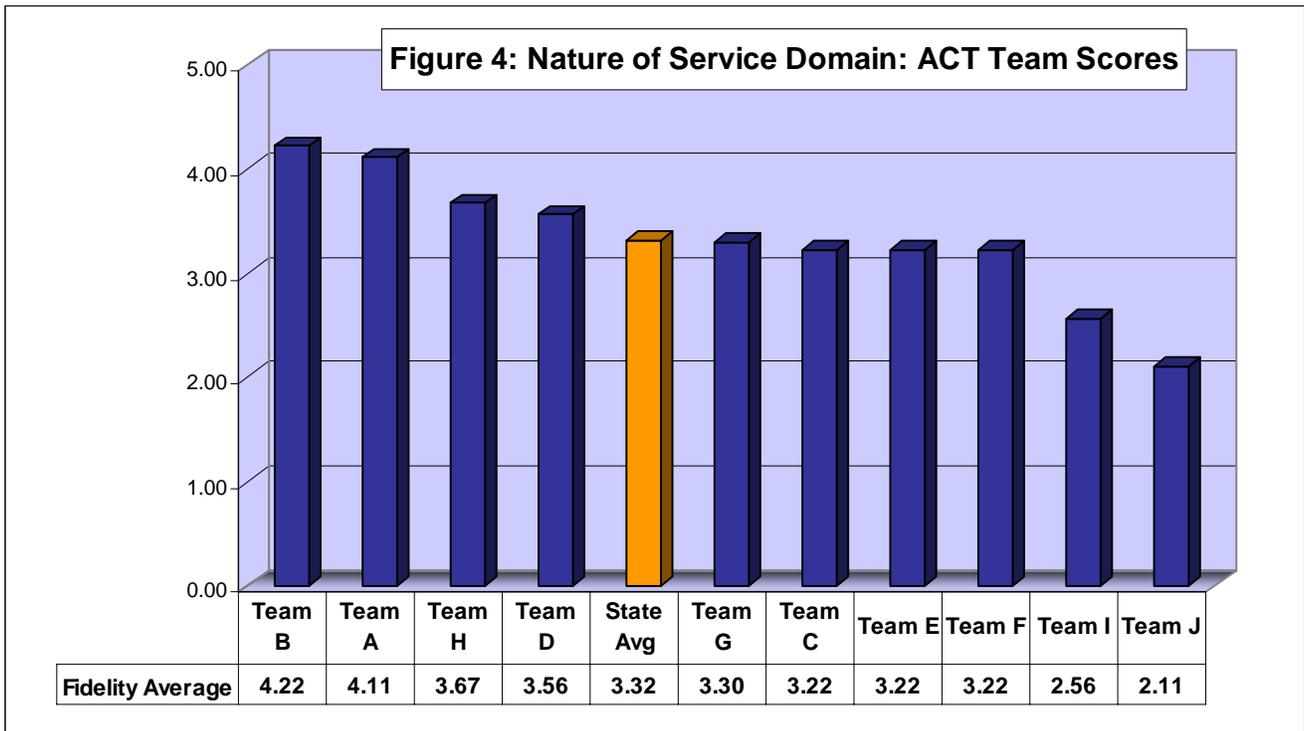
The uniform high implementation ratings in this area combined with high ratings in the Human Resources domain indicate that ACT teams are operating as multi-disciplinary teams and generally have the capacity to provide all required services to ACT recipients.

Area of Need: Responsibility for Hospital Admissions (Item O: 5) received the lowest statewide implementation rating in the Organizational Boundaries Domain area. A rating of 4 indicates that the ACT team is involved in 65% to 94% of admissions. Full implementation requires that an ACT team is involved in 95% or more admissions.

Nature of Services Domain

The Nature of Services domain evaluates how ACT team members deliver services to ACT recipients. Examples of this would be 1) how often ACT team members make face-to-face contact with an individual, 2) how often individual contacts are made in the community versus in the ACT office and 3) to what extent are ACT team members working with an individual’s informal network.

Implementation for this domain were quite variable across ACT teams and yielded substantially lower implementation ratings (Average Domain Score of 3.32) compared to the domains of Human Resources (average domain score of 4.28) and Organizational Boundaries (average domain score of 4.56). As shown in figure 4, individual ACT teams differed widely in their level of implementation ratings, ranging from 2.11 to 4.22.



The Nature of Services domain contains nine implementation items as illustrated in table 5. As shown in the table, statewide average ratings for each item ranged from 2.1 to 4.3.

Table 5: Nature of Services Domain Items	State Average Fidelity Scores
S1: Community Based Services: Program works to monitor status, develop community living skills in the community rather than the office.	3.3
S2: No Dropout Policy: Program retains a high percentage of its clients.	3.9
S3: Assertive Engagement Mechanisms: As part of assuring engagement, program uses street outreach, as well as legal mechanisms.	4.3
S4: Intensity of Services: High total amount of service time as needed.	4
S5: Frequency of Contact: High number of service contacts as needed.	2.6
S6: Work with Informal Support System: With or without client present, program provides support and skills for client's support network: family, landlords, employers.	2.4
S7: Individualized Substance Abuse Treatment: One or more members of the program provide direct treatment and substance abuse treatment for clients with substance use disorders.	3.5
S8: Dual Disorder Treatment Groups: Program uses group modalities as a treatment strategy for people with substance use disorders.	2.1
S9: Dual Disorder Model: Program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	3.8
Statewide Average Nature of Services Domain	3.32

Area of Strength: *Intensity of Contact*-- With an average statewide fidelity rating of 4.00, most ACT teams received high implementation ratings for item S4: *Intensity of Service: High total amount of service time as needed* (See Table 6 below). Most teams (7 out of 10 teams) were committing 85 to 119 minutes each week of face-to-face contacts with individuals receiving ACT services. The additional three teams, with ratings of 2 or 3, were committing only 49 minutes or less per week for face-to-face contacts per individual.

Table 6: Intensity of Contact Fidelity Scores by Individual ACT Team											
Domain Item	Team A	Team B	Team C	Team D	Team E	Team F	Team G	Team H	Team I	Team J	State Avg
S4	5	5	4	4	5	3	4	3	2	5	4

Area of Need: *Dual Disorder Treatment*--Both items S7 and S8 examine substance abuse treatment for individuals receiving ACT services. Item S7 determines that one or more members of the ACT Team provide direct treatment for individuals with substance use disorders. Item S8 determines that the ACT team uses group treatment modalities as a strategy for people with substance use disorders.

Table 7 shows implementation scores for each ACT team for these items. Five of the ten ACT teams reviewed fell below the state average on both items. A total of five teams fell below the statewide average of 3.5 on individualized substance abuse treatment (Item S7) while six teams fell below the statewide fidelity average of 2.1 on Dual Disorder treatment groups (Item S8).

Review of items in Human Resources and Organizational Boundaries domains indicate that substance abuse staff are generally available on ACT teams and that individualized substance abuse treatment services are available to ACT recipients. However, the delivery of dual disorder services varied substantially across ACT Teams resulting in low to moderate implementation scores for the availability and use of individualized substance abuse treatment and dual diagnosis group treatment alternatives.

Table 7: Dual Disorder Fidelity Scores by Individual ACT Team											
Domain Item	Team A	Team B	Team C	Team D	Team E.	Team F	Team G	Team H	Team I	Team J	State Avg
S7	5	4	3	5	3	3	4	4	3	1	3.5
S8	4	3	2	1	1	1	3	4	1	1	2.1

Please note that many teams reported that unless individuals diagnosed with a dual disorder recognized his/her need for substance abuse treatment, the identification for dual disorder treatment would not be addressed in the Individual Support Plans. This fidelity review only examined those records of individuals with dual disorder treatment objectives in their current ISP to evaluate Item S7 and S8.

Area of Need: *Community Contact*--Item S1 examined whether ACT teams are working with individuals to develop community living skills in the community rather than in office based settings. This was based on a 4-week review of contact notes in the individual case file. As shown in Table 8 (below), the statewide average implementation rating on this area was relatively low, receiving a score of 3.3. These results indicate that only 40 to 59 percent of ACT team face-to-face contacts with individuals occurred in community-based locations. Full implementation requires that 80% or total face-to-face contacts occur in the community.

Domain	Team	State									
Item	A	B	C	D	E	F	G	H	I	J	Avg
S1	3	4	2	4	5	5	2	4	1	3	3.3

- As shown in Table 8, four out of the ten teams fell below the statewide average on this item. When reviewing implementation scores with individual ACT teams upon the completion of the review, teams had an opportunity to comment on their scores. Teams varied in their perceptions and expectations of community contacts.

Area of Need: *Frequency of Contact*-- Overall, ACT teams scored uniformly low on item S5 *Frequency of Contact: High number of service contacts as needed*. The statewide average rating for this item was 2.6 (Table 9 below). A score of 2.6 demonstrates a low level of implementation, indicating that ACT Teams averaged 1 to 2 face-to-face contacts with an individual during any given week.

- For most teams, the implementation score was lower on frequency of contact than duration of contact (S4), Team D and Team E attributed this to a larger catchments area and that although face-to-face contacts are only once to twice a week, duration of those visits are longer.
- Team I noted that this likely is a documentation need for their team and has since implemented improved practices in its team’s documentation of face-to-face visits with individuals.

- Team F attributed the low implementation in this area to the definition of face-to-face contacts and that it should include telephone contacts as well. The team discussed that it is not unusual for individuals receiving ACT services to request telephone only contact. Individuals are not always comfortable with leaving his/her home or having an ACT team member visit. In these cases, the objective of the ACT team is to maintain contact and develop trust so that face-to-face contacts can occur in the community.

Table 9: Frequency of Contact Fidelity Scores by Individual ACT Team

Domain	Team	State									
Item	A	B	C	D	E	F	G	H	I	J	Avg
S5	3	5	2	3	2	2	2	2	2	3	2.6

Results from ACT Services

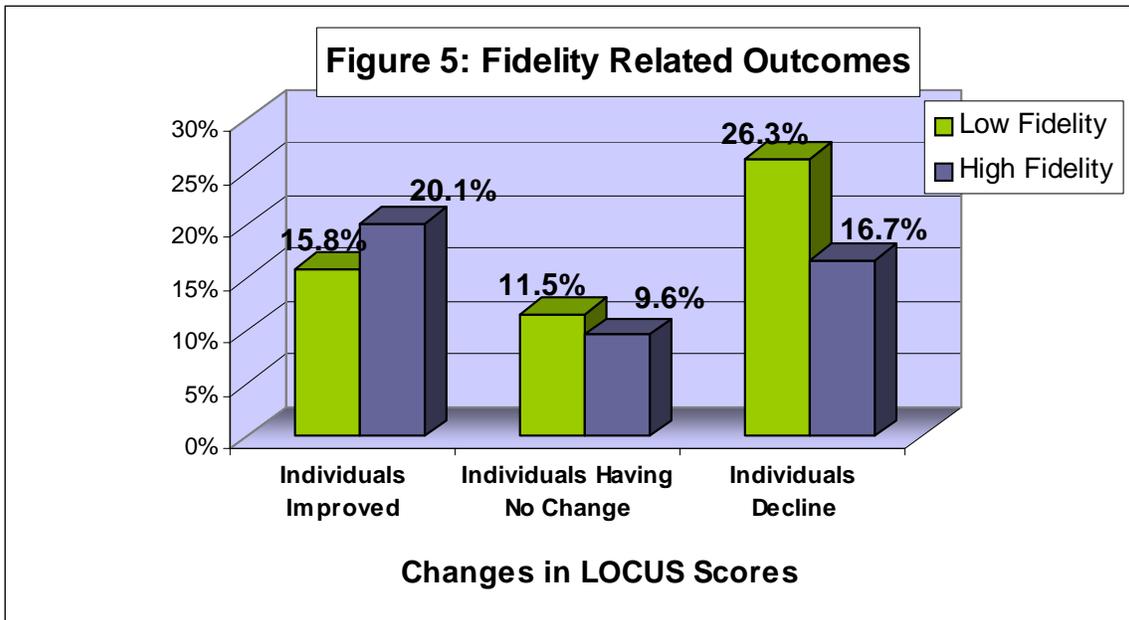
Measuring the extent to which individual ACT Teams adhere to the ACT model is only part of evaluating ACT services in Maine. Outcomes must also be evaluated to determine if individuals are achieving desired outcomes as a result of receiving ACT services. To better understand what outcomes are linked to level of implementation for ACT services in Maine, the Office of Quality Improvement has begun a preliminary analysis of the relationship between ACT implementation scores and improvement in functional status for individual recipients of ACT services.

These analyses examined the extent to which team ratings are associated with improvement in functioning as assessed by change in Level of Care Utilization System (LOCUS) over the ACT study period.

Preliminary Results

Preliminary findings showed that those individuals receiving ACT services from teams with higher overall implementation ratings were more likely to experience improvements in functioning over time and individuals receiving services from teams having lower

implementation were more likely to experience a decline or no change in functioning between LOCUS assessments. (Figure 5)



Further examination of the relationships between each implementation item and improved outcomes identified several ACT implementation items that contributed significantly to improvements in functioning over the study period. They included:

- *Full Responsibility for Treatment Services:* In addition to case management, the team directly provides psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.
- *Work with Informal Support System:* With or without individual present, program provides support and skills for individual's support network: family, landlords, employers.
- *Frequency of Contact:* High number of service contacts as needed.

Next Steps

The Office of Quality Improvement is continuing to evaluate the relationship between ACT team fidelity scores and individual outcomes. Further work is planned to investigate the relationship between level of implementation by ACT team and the use of high cost services, including: crisis services, acute inpatient hospitalization, and residential/group treatment. It is expected that high fidelity teams will be more successful in supporting individuals in the community and limiting the use of crisis services and inpatient hospitalizations. This work will also involve re-examining the relationship between team fidelity scores and consumer outcomes using a larger sample of ACT recipients.

Conclusion

The purpose of this review was to evaluate 1) the nature of ACT service delivery and practice in Maine and to examine the extent to which ACT services adhere to established practice standards and 2) to examine whether high implementation relates to improved outcomes for individuals receiving ACT services. The following summary of key findings highlight both strengths and weaknesses of ACT services in Maine and provide a starting point for improving the quality and consistency of ACT services:

- *Critical personnel resources of ACT services are present and teams are mostly providing services as a team;*
- *Teams are challenged with providing substance abuse services both at an individual and group level to those with dual disorders;*
- *Teams are not necessarily providing the services from a community orientation;*
- *The following items were found to have significant link to improved functional outcomes for individuals receiving ACT services:*
 - *Frequency of Contact (Nature of Services Domain)*
 - *High number of face-to-face contacts per week*
 - *Full Responsibility for Treatment Services (Organizational Boundaries Domain)*

- *In addition to case management and psychiatric services, program directly provides counseling/psychotherapy, housing support, substance abuse treatment, employment, and rehabilitative services.*
- *Information Support System (Nature of Services Domain)*
 - *With or without recipient of ACT services present, provide support and skill for individual support network in the community (family, landlord, employers, etc)*

APPENDICES

CRITERION		RATINGS/ANCHORS				
HUMAN RESOURCES: STRUCTURE & COMPOSITION		(1)	(2)	(3)	(4)	(5)
H1	SMALL CASELOAD: Client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	11 - 20	10 clients/clinician or fewer
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 36%.	37 - 63%.	64 - 89%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.
H3	PROGRAM MEETING: Program meets frequently to plan and review services for each client.	Program service-planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.
H5	CONTINUITY OF STAFFING: Program maintains same staffing over time.	Greater than 80% turnover in 2 years.	60-80% turnover in 2 years.	40-59% turnover in 2 years.	20-39% turnover in 2 years.	Less than 20% turnover in 2 years.
H6	STAFF CAPACITY: Program operates at full staffing.	Program has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	80-94%	Program has operated at 95% or more of full staffing in past 12 months.
H7	PSYCHIATRIST ON STAFF: There is at least one full-time psychiatrist per 100 clients assigned to work with the program.	Program for 100 clients has less than .10 FTE regular psychiatrist.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	.70-.99 FTE per 100 clients	At least one full-time psychiatrist is assigned directly to a 100-client program.

<i>HUMAN RESOURCES: STRUCTURE & COMPOSITION CONT.</i>		(1)	(2)	(3)	(4)	(5)
H8	NURSE ON STAFF: There are at least two full-time nurses assigned to work with a 100-client program.	Program for 100 clients has less than .20 FTE regular nurse.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client program.
H9	SUBSTANCE ABUSE SPECIALIST ON STAFF: A 100-client program includes at least two staff members with 1 year of training or clinical experience in substance abuse treatment.	Program has less than .20 FTE S/A expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year S/A training or supervised S/A experience.
H10	VOCATIONAL SPECIALIST ON STAFF: The program includes at least two staff members with 1 year training/experience in vocational rehabilitation and support.	Program has less than .20 FTE vocational expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.
H11	PROGRAM SIZE: Program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.	Program has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	7.5 - 9.9	Program has at least 10 FTE staff.
ORGANIZATIONAL BOUNDARIES		(1)	(2)	(3)	(4)	(5)
O1	EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined mission but the admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most referrals.	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	The program actively recruits a defined population and all cases comply with explicit admission criteria.
O2	INTAKE RATE: Program takes clients in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 clients/month.	13 -15	10 - 12	7 - 9	Highest monthly intake rate in the last 6 months no greater than 6 clients/month.
O3	FULL RESPONSIBILITY FOR TREATMENT SERVICES: In addition to case management, program directly provides psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative svcs	Program provides no more than case management services.	Program provides one of five additional services and refers externally for others.	Program provides two of five additional services and refers externally for others.	Program provides three or four of five additional services and refers externally for others.	Program provides all five of these services to clients

<i>ORGANIZATIONAL BOUNDARIES CONT.</i>		(1)	(2)	(3)	(4)	(5)
O4	RESPONSIBILITY FOR CRISIS SERVICES: Program has 24-hour responsibility for covering psychiatric crises.	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program clients.	Program is available by telephone, predominantly in consulting role.	Program provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement.	Program provides 24-hour coverage
O5	RESPONSIBILITY FOR HOSPITAL ADMISSIONS: Program is involved in hospital admissions.	Program has involvement in fewer than 5% decisions to hospitalize.	ACT team is involved in 5% -34% of admissions.	ACT team is involved in 35% - 64% of admissions.	ACT team is involved in 65% - 94% of admissions.	ACT team is involved in 95% or more admissions.
O6	RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: Program is involved in planning for hospital discharges.	Program has involvement in fewer than 5% of hospital discharges.	5% - 34% of program client discharges are planned jointly with the program.	35 - 64% of program client discharges are planned jointly with the program.	65 - 94% of program client discharges are planned jointly with the program.	95% or more discharges are planned jointly with the program.
O7	TIME-UNLIMITED SERVICES (GRADUATION RATE): Program rarely closes cases but remains the point of contact for all clients as needed.	More than 90% of clients are expected to be discharged within 1 year.	From 38-90% of clients are expected to be discharged within 1 year.	From 18-37% of clients are expected to be discharged within 1 year.	From 5-17% of clients are expected to be discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.
NATURE OF SERVICES		(1)	(2)	(3)	(4)	(5)
S1	COMMUNITY-BASED SERVICES: Program works to monitor status, develop community living skills in the community rather than the office.	Less than 20% of face-to-face contacts in community.	20 - 39%.	40 - 59%.	60 - 79%.	80% of total face-to-face contacts in community
S2	NO DROPOUT POLICY: Program retains a high percentage of its clients	Less than 50% of the caseload is retained over a 12-month period.	50- 64%.	65 - 79%.	80 - 94%.	95% or more of caseload is retained over a 12-month period

NATURE OF SERVICES CONT.		(1)	(2)	(3)	(4)	(5)
S3	ASSERTIVE ENGAGEMENT MECHANISMS: As part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., probation/parole, OP commitment) as indicated and as available.	Program passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients.	Program attempts outreach and uses legal mechanisms only as convenient.	Program usually has plan for engagement and uses most of the mechanisms that are available.	Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.
S4	INTENSITY OF SERVICE: High total amount of service time as needed.	Average of less than 15 min/week or less of face-to-face contact per client.	15 - 49 minutes / week.	50 - 84 minutes / week.	85 - 119 minutes / week.	Average of 2 hours/week or more of face-to-face contact per client.
S5	FREQUENCY OF CONTACT: High number of service contacts as needed	Average of less than 1 face-to-face contact / week or fewer per client.	1 - 2 / week.	2 - 3 / week.	3 - 4 / week.	Average of 4 or more face-to-face contacts / week per client.
S6	WORK WITH INFORMAL SUPPORT SYSTEM: With or without client present, program provides support and skills for client's support network: family, landlords, employers.	Less than .5 contact per month per client with support system.	.5-1 contact per month per client with support system in the community.	1-2 contact per month per client with support system in the community.	2-3 contacts per months per client with support system in the community.	Four or more contacts per month per client with support system in the community.
S7	INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT: One or more members of the program provide direct treatment and substance abuse treatment for clients with substance use disorders.	No direct, individualized substance abuse treatment is provided by the team.	The team variably addresses SA concerns with clients; no formal, individualized SA treatment provided.	While the team integrates some substance abuse treatment into regular client contact, they provide no formal, individualized SA treatment.	Some formal individualized SA treatment is offered; clients with substance use disorders spend less than 24 minutes/week in such treatment.	Clients with substance use disorders spend, on average, 24 minutes / week or more in formal substance abuse treatment.
S8	DUAL DISORDER TREATMENT GROUPS: Program uses group modalities as a treatment strategy for people with substance use disorders.	Fewer than 5% of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.	5 - 19%	20 - 34%	35 - 49%	50% or more of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.

<i>NATURE OF SERVICES CONT.</i>		(1)	(2)	(3)	(4)	(5)
S9	DUAL DISORDERS (DD) MODEL: Program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	Program fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Program uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for persuasion of clients in denial or who don't fit AA.	Program uses mixed model: e.g., DD principles in treatment plans; refers clients to persuasion groups; uses hospitalization for rehab.; refers to AA, NA.	Program uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalize for rehab. nor detox except for medical necessity; refers out some s/a treatment.	Program fully based in DD treatment principles, with treatment provided by program staff.
S10	ROLE OF CONSUMERS ON TREATMENT TEAM: Consumers are involved as members of the team providing direct services.	Consumers have no involvement in service provision in relation to the program.	Consumer(s) fill consumer-specific service roles with respect to program (e.g., self-help).	Consumer(s) work part-time in case-management roles with reduced responsibilities.	Consumer(s) work full-time in case management roles with reduced responsibilities.	Consumer(s) are employed full-time as clinicians (e.g., case managers) with full professional status.

ATTACHMENT 2—Letter to ACT Teams

December 22, 2005

Dear Executive Director:

Over the past several years, a small group of providers in Maine have offered the Assertive Community Treatment model. The DHHS Office of Integrated Services Quality Improvement in collaboration with the Office of Adult Mental Services is planning a review of current Assertive Community Treatment Services in Maine. The review process will utilize the protocol from the ACT Implementation Resource Kit and the ACT Fidelity Scale, which has been provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). You may review the ACT Implementation Resource Kit and ACT Fidelity Scale at www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits.

The review is intensive and requires interviews with individuals receiving ACT services, clinicians, team leaders, case managers, as well as randomly selected chart reviews. The review is not intended to be a pass or fail indicator of ACT services but is intended to be an assessment on the level of fidelity of ACT services in Maine and what systematic supports can be made available to increase fidelity within ACT services. Therefore, information will be aggregated and forwarded to Adult Mental Health Services. Adult Mental Health Services will review this information as well as the information generated by the service reviews to get a fuller picture of not only fidelity to ACT standards but also a picture of the population being served by ACT.

In addition to a systematic review, providers will receive feedback on the ACT services being provided in their agency and where their services fall on the fidelity scale. The agency profile generated from this review can serve as an objective, structured mechanism to provide feedback to consumers and program staff.

The importance of consistent and ongoing fidelity checks within Evidence Based Practices is highlighted in The President's New Freedom Commission on Mental Health's final report, and is also reflected in DHHS' Data Infrastructure Grant (DIG). The DIG is funded by SAMHSA and administered by DHHS' Office of Integrated Services Quality Improvement. The grant requires implementation of Adult Mental Health Evidence Based Practice fidelity assessment for Assertive Community Treatment, Supported Employment and Supported Housing during the next two years.

It is hoped that by utilizing the ACT Implementation Resource Kit and fidelity check the review will be engaging, insightful and will assist the State of Maine to assess the quality, availability and accessibility of ACT services for adults with serious mental illness. It is anticipated that the reviews will occur during late January and February.

The Offices of Adult Mental Health Services and Integrated Services Quality Improvement are sponsoring a forum in Portland on January 17th to kick off the process. The forum will serve as a review of the ACT standards as well as lessons learned. Please see attached information.

Please complete the enclosed cover sheet. The Office of Integrated Services Quality Improvement will telephone the individual you have listed as your agency's contact person to begin coordinating your review. If you have any questions about the review please do not hesitate to contact either of us at 287-8982 (Jay.Yoe@maine.gov) or at 287-4271 (Marya.Faust@maine.gov).

Sincerely,

Marya Faust, Quality Care Manager
Adult Mental Health Services, DHHS

Jay Yoe, Director
Office of Integrated Services QI



Department of Health and Human Services

*Maine People Living
Safe, Healthy and Productive Lives*

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

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