ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 9, 2018

To: Peggy Chase
President, Chief Executive Officer
Terros Health

From: Karen Voyer-Caravona, MA, LMSW
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AHCCCS Fidelity Reviewers

Method

On October 9 – 10, 2018, Karen Voyer-Caravona and Thomas Eggsware completed a review of the Terros Health 51st Avenue Recovery Center 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.

The ACT team is operated by Terros, a comprehensive healthcare organization. Founded in 1969, Terros offers mental illness and co-occurring treatment; their services seek to integrate behavioral health and primary medical care. The ACT team is located at the 51st Ave Recovery Center, 4316 N. 51st Avenue in Phoenix, sharing space with supportive teams, as well as the Ladder substance abuse treatment program.

The individuals served through the agency are referred to as *clients* and *members*, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used. Groups at the 51st Avenue Recovery Center are referred to at the clinic as "classes" however, for consistency across reviews, the term "group" will be used.

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

- Observation of a daily ACT team meeting on Tuesday, September 9, 2018;
- Individual interview with the team leader/Clinical Coordinator (CC);
- Individual interviews with ACT Counselor (AC), Rehabilitation Specialist (RS) and Housing Specialist (HS);
- Group interview with five members receiving ACT services;
- Ten randomly selected member records were reviewed using the agency's electronic medical records system; and
- Review of agency provided documents including: Resumes and training records for the AC, RS, and ES; encounter reports for the CC and AC; the AC's calendar log of individual contacts and handwritten log of co-occurring group attendance; the 51st Ave ACT Team list of staff contact numbers, and the 51st Ave ACT Team's *Client Survey* and *Natural Supports Survey*; Regional Behavioral Health Authority (RBHA) developed *ACT Eligibility Screening Tool* and *ACT Exit Criteria Screening Tool*; and the ACT team's written *Outreach Process*.

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 ACT team has a licensed Social Worker who serves as the ACT Counselor (AC) to provide counseling/psychotherapy and individual and group co-occurring treatment. The AC is well-versed in the principles of co-occurring treatment and conducts weekly clinical oversight in this area to the other team specialists.
- The ACT team has full responsibility for 24-hour crisis services, seven days a week. Staff rotate coverage of on-call duties weekly, as well as daily for "blue dot" coverage in the clinic during business hours.
- The ACT team was directly involved in 100% of the last ten psychiatric hospital admissions, and staff reported that it reflects the norm. Staff makes use of legal mechanisms, when necessary to facilitate psychiatric hospitalization when members are presenting as a danger to themselves or others, working with law enforcement to safely transport members to care.

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

- Ensure that all members have access to full-time psychiatric coverage with the goal being a permanent ACT Psychiatrist whose time is fully dedicated to their care. There was turnover at the Psychiatrist position prior to the review. Based on interviews, it appears multiple agency Prescribers provided partial coverage before the current Psychiatrist joined the team. Staff reporting of the current Psychiatrist's start date differed from a date that was ultimately reported by an agency administrator.
    - The majority of member records reviewed showed no contacts with a permanent or covering ACT prescriber since mid-July 2018.
- The ACT team should provide most of the behavioral health services, with staff empowered to function in their area of specialization. Interviews with some staff and members, as well as documentation in member records, suggest that the staff operate primarily as case managers rather than within areas of specialization. The team appears to rely on a brokered provider for supportive employment services. More than 10% of members are residents in staffed or semi-staffed locations. There was a lapse in Psychiatric coverage.
- The ACT team should increase the frequency and intensity of services. Emphasize service delivery in natural, integrated community settings, outside of the clinic, where learning of new skills and behaviors, as well as modeling, monitoring, and feedback, best occurs. Member records showed that a significant portion of community-contacts focused on medication observations and assessments of living environments; members were often encouraged to come to the clinic to attend unspecified groups rather than engaged to explore challenges and personally meaningful recovery goals in the context relevant settings.
- The CC and AC should collaborate with all team specialists to increase attendance in the co-occurring groups. It is recommended that

co-occurring groups be ACT member specific in order to best respond to the recovery needs of members with the most significant behavioral health challenges. The agency should prioritize hiring of a qualified Substance Abuse Specialist (SAS) and consider co-occurring group formats that align member change stages with appropriate objectives and interventions (stage-wise treatment approach) which may increase participation and support forward movement in recovery.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review 98 members were provided services by nine full-time staff, excluding the Psychiatrist. Those staff are: Clinical Coordinator (CC), ACT Counselor (AC), Employment Specialist, Rehabilitation Specialist (RS), Housing Specialist (HS), Peer Support Specialist (PSS), Nurse, Independent Living Specialist (ILS), and ACT Specialist (AS). A second Nurse (Nurse2) began transitioning to the team the week of the review, filling a recent vacancy. Because the Nurse2 was still following members on the supportive team, Nurse2 was not yet dedicated full-time to the ACT team. The member to staff ratio was over 10:1.	
H2	Team Approach	1 – 5 4	Per a review of 10 randomly selected electronic member records, 70% of member's face-to-face contact was with more than one ACT team member in a two week period. Records showed that certain staff members provided the majority of face-to-face contacts. Staff interviewed said that they are assigned primary caseloads; caseloads by specialty/needs or quality of staff/member rapport. Staff are responsible for maintaining up to date paperwork on their caseload as well as primary responsibility for other needs such as appointment reminders and transportation, budgeting, and assistance with obtaining resources. Caseloads generally don't rotate except for changes in the member roster or staff turnover. Staff said that all specialists pitch in and assist one another. On call staff have additional responsibilities for after hours and weekend coverage, typically seeing additional	• Increase the percentage of members seen by more than one staff member in a two week period, with a goal of 90% or more. Consider strategies such as a zone coverage system or a rotating coverage schedule to increase diversity of member contacts with staff. • Rather than functioning as case managers, train and empower specialists to function within the area of their specialization. Staff should be making face-to-face contacts responding to goals and objectives identified on member service plans.

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			members, including those who are hospitalized.	
H3	Program Meeting	1 – 5 4	The ACT team meets four days a week for a program meeting where all members are discussed. On Wednesdays, the team meets for staffings and co-occurring clinical oversight provided by the AC. At the meeting observed by the reviewers, all members were discussed and all staff present were engaged. The ACT Psychiatrist, whom it was reported had joined the team that week, was not present for the meeting. Per interviews and records reviewed, it was not clear that a permanent or covering Psychiatrist had regularly attended program meetings since mid-August 2018. Staff were inconsistent in their reports of how the Nurses regularly attended program meetings, with one staff person reporting that Nurses might be in their adjoining office during the meeting.	• The ACT Psychiatrist is a key staff member of any ACT team, frequently sharing leadership responsibilities with the CC, as well as clinical oversight, education regarding diagnosis and medication, and insights gleaned during scheduled psychiatric evaluations and discussions with family members and other behavioral health professionals. Ensure that the ACT Psychiatrist attends at least one program meeting per week. • Both ACT Nurses should be present and actively engaged in all program meetings.
H4	Practicing ACT Leader	1 – 5 3	The CC estimates that he spends 40% of his time providing direct member services. The CC reported that he provides services both in the clinic and in the community. In addition to performing home visits and medication observations, the CC said that he facilitates the Speak Up group every Monday from 11 – noon, in which members have the opportunity to ask questions and bring up issues of concern related to their treatment, the team or the clinic. These activities were evidenced in the CC's real time encounter log for a recent 30 day period. The encounter log showed that 13% of the CC's time was spent delivering direct member services.	• Increase face-to-face member contacts to 50%, including time spent shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery. • The CC and the agency should identify any administrative functions not essential to the CC's time that could be performed by the program assistant or other administrative staff.
H5	Continuity of Staffing	1 – 5 4	In the last 24 months, five staff left the team for an attrition rate of 21%, a significant improvement over the previous period of review. Further, the	• Continue efforts to retain qualified staff to reduce turnover rate to no more than 20% in two years to promote therapeutic

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			ACT team retained all but two staff in the last 12 months, for an annual attrition rate of 8%. One position, that of the Substance Abuse Specialist, has proved difficult to fill, with that role vacant for just over 12 months; staff reported an offer has been made to a candidate. Staff interviewed reported generally good morale among staff members and the belief that they work well together. One staff member described valuing support received in professional development.	relationships, staff cohesion, and for maximizing the benefits of specialty training and other professional developments efforts. • Given the low rate of staff turnover in the last 12 months, the agency and the RBHA may wish to explore factors that may have contributed to staff retention.
H6	Staff Capacity	1 – 5 4	For the 12 month review period, a total of 16 positions were open on the ACT team for a capacity rate of 89%. The open SAS position, traditionally a more difficult role to fill, accounted for 12 of those openings.	• Hire and retain qualified staff to maintain a staffing capacity of 95% or greater.
H7	Psychiatrist on Team	1 – 5 2	At the time of the review, the ACT team had been without a permanent Psychiatrist for 45 days. Staff reported another agency ACT Psychiatrist had been providing coverage, the amount and nature of which was unclear to the Reviewers. Staff said that during the transition period, the covering prescribers prioritized members discharging from inpatient psychiatric care and those on court ordered treatment and special assistance. Eight of ten member electronic records sampled showed no documented contact between members and a prescriber for 45 days prior to the review. Although not present at the program meeting observed by the Reviewers, staff reported that a new ACT Psychiatrist started with the team the day before the review. Staff said the new Psychiatrist had been assigned to a supportive team at the clinic, was known to ACT staff, and familiar with many ACT members. Per interview, the Psychiatrist was still transitioning from a supportive team at the clinic; the reviewers were	• Transition the new Psychiatrist to the ACT team so that her time is fully dedicated to ACT member care. • Ensure that covering prescribers' documentation is present in member records in a timely manner.

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			provided with conflicting information about how much of the Psychiatrist's time was currently devoted to ACT member care. Data provided the reviewers, however, showed that for the week of the review, the new Psychiatrist was scheduled for appointments with seven ACT members, while another seven were scheduled for the covering Psychiatrist. Clear and consistent reports about when the Psychiatrist would be completely transitioned to the team were not provided the Reviewers.	
H8	Nurse on Team	1 – 5 3	The ACT team has two Nurses. Nurse1 is has been with the ACT team for over a year, is assigned full time to the ACT team and has no other duties or responsibilities. Nurse2 joined the ACT team a day prior to the review; she had been assigned to a supportive team at the clinic and occasionally provided nursing coverage to the ACT team. Although hired as a full-time nurse, Nurse2 was still seeing members from the supportive team as she transitions to the ACT caseload. Per data provided the Reviewers, Nurse2 was scheduled to see 14 ACT members during the week of the review. Clear and consistent reports about when Nurse2 would be fully transitioned to the team were not provided the Reviewers.	• Transition Nurse2 to the ACT team so that her time is fully dedicated to ACT member care.
H9	Substance Abuse Specialist on Team	1 – 5 3	The ACT team has an ACT Counselor who is well-qualified to provide substance abuse counseling to members diagnosed with a co-occurring disorder. The AC is a Licensed Master Social Worker (LMSW) and has been in the position providing COD treatment individually and in group format for two years. Because the Substance Abuse Specialist position has been vacant for over a year, the AC is the only staff providing these services and is also the specialist with primary responsibility for cross-	• Hire and retain a qualified SAS to provide for the substance abuse treatment needs of the teams 49 members with a COD and participate in cross training and mentoring other specialists on the team.

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			training other staff in COD treatment. The AC provides weekly clinical oversight in this area during the Wednesday staffing meeting. Although, data showed that six supportive team members attended ACT co-occurring groups, it cannot be determined how or if this impacts the AC's accessibility to ACT members.	
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has two vocational specialists, an Employment Specialist (ES) and a RS. The ES has been in the position for two years, and limited training in employment/vocational services in his Relias training transcript. The RS has been with the team for about 18 months and has evidence of several employment/vocational trainings in her Relias training transcript. While it was reported to the Reviewers that both staff attend ACT ES/RS Quarterly Meetings provided by the RBHA, these appear to be administrative in nature rather than focused on developing skills in assisting members in obtaining employment in integrated settings. Although ten records sampled showed that both vocational staff provided a considerable percentage of direct member services, the Reviewers found no evidence in member records, or staff interviews, that vocational staff assist members in finding work in integrated settings. Staff interviewed appeared to default to sheltered employment and work adjustment trainings when asked about assisting members with finding jobs.	• Vocational staff may benefit from direct mentoring and specific training/technical assistance in supporting people living with SMI/COD in finding and retaining employment in integrated settings. Work in integrated settings is recognized as an essential part of recovery that supports positive outcomes such as higher self-esteem, better control of psychiatric symptoms, and life satisfaction attained through participation in society.
H11	Program Size	1 – 5 4	At the time of the review the ACT team was being served by nine full-time staff whose time was 100% dedicated to ACT members. The Psychiatrist and Nurse2 were transitioning from supportive teams where they were still seeing members; it was not clear from interviews when the transition would be complete. As noted earlier in the report,	• Fully transition the Psychiatrist for the required size and diversity of specialization to fulfill the ACT mission of providing integrated behavioral health services through a variety of perspectives.

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			most records reviewed showed a lack of contact with a covering prescriber over the last month and a half.	
O1	Explicit Admission Criteria	1 – 5 4	The ACT team uses the RBHA's ACT Eligibility Screening Tool to assess appropriateness of admission to the ACT team. Staff said the typical ACT member presents with an SMI diagnosis such as bipolar disorder or schizophrenia, is a high utilizer of emergency rooms and psychiatric hospitals, lacks a support system, and needs support for housing and employment. Referrals primarily originate from the RBHA but also can come from inpatient settings, supportive teams, and occasionally other ACT teams. The CC conducts most of the screenings, but other staff are also trained to do so. The CC staffs the referral with the Psychiatrist to make the final determination of appropriateness for ACT services. Staff interviewed stated that they do not generally encounter any administrative pressure to accept members who are not appropriate. However, it was reported that though the CC declined admission of a referral that did not meet the full criteria, the RBHA determined that the person should be admitted due to repeated psychiatric hospitalizations necessitating medication observations.	• ACT is designed for a specific population of members who do no effectively use less intensive mental health services. Admissions to the ACT team should meet the criteria. ACT teams, which base admissions on an established admission criteria should have full control over admissions.
O2	Intake Rate	1 – 5 4	For the six months previous to the review, the ACT team admitted 21 new members: five in April, two in May, seven in June, three in July, three in August, and one in September.	• Limit admissions to the ACT team to no more than six in one month.
O3	Full Responsibility for Treatment Services	1 – 5 3	Along with case management services, the ACT team is fully responsible for substance abuse and counseling/psychotherapy services.	• Continue efforts to assist members in obtaining housing in integrated settings and provided necessary housing support to retain tenancy.

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			Although the ACT team provides housing support services to members, over 10% of members reside in settings that include some level of support services. It was noted by the Reviewers that staff frequently used the term "placement", which suggests an institutional setting, in lieu of "home", "house" or "apartment". It does not appear that the team fully provides employment support services. Staff interviewed reported that members interested in competitive employment are referred to an outside supported employment provider co-located at the clinic. While staff said the ACT team can help members with resumes and job searches, it was not clear from interviews to what extent vocational staff have assisted members in obtaining competitive work since staff interviewed primarily discussed member participation in sheltered work and work adjustment training (WAT). In three records reviewed, member service plans listed either employment goals or objectives, but showed no evidence of vocational staff engaging members in these or related services. The team did not appear to be providing psychiatric services to all members of the ACT team for the last month and a half prior to the review.	• ACT vocational staff should embrace evidence-based practice principles of competitive employment for SMI and co-occurring members. Ensure that staff receive training, mentoring, and oversight in supporting and maintaining member's motivation and enthusiasm for work in integrated settings. • Ensure a swift transition of the new Psychiatrist from her previous assignment to the ACT team so that all members receive the full scope of psychiatric care.
O4	Responsibility for Crisis Services	1 – 5 5	Per interviews, the ACT team described full responsibility for crisis services, 24 hours a day, seven days a week. The team has an on-call staff, and the CC is the back up to the on-call. The on-call phone rotates weekly among the staff. Staff rotate "blue dot" duties at the clinic daily for crisis calls that arrive there during business hours. Staff said they give members the number to the on-call	• Ensure that the crisis services flyer is updated regularly with a list of current ACT staff and phone numbers.

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			phone, often writing it down for them and putting it somewhere in their home where they can find it. Staff said they also give members a copy of a flyer with staff cell numbers, although a copy provided the reviewers showed some staff names were not current. Staff will respond in the community to crisis. Staff said that when members call the crisis line, that service transfers the call to the ACT on-call. Staff transport members to the Urgent Psychiatric Center (UPC) when necessary. Public safety may be called if it is not safe for staff to transport.	
O5	Responsibility for Hospital Admissions	1 – 5 5	Per a review with the CC, of the last ten psychiatric hospital admissions, the ACT team was directly involved in all of them. In seven cases, members were transported directly to psychiatric hospitals by ACT staff. In two cases, the police were called to transport while staff filed petitions or completed emergent amendments. In one case, the fire department took the member to the emergency room, and after the member refused treatment, the ACT team went to the hospital and completed an emergent amendment.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Per a review of the last ten psychiatric hospital discharges with the CC, the ACT team was directly involved with 90% of them. In one case, a member's mother picked up the member from the hospital without notifying the clinical team; the team however did meet with the member at home on the same day following the discharge. Staff said that discharge planning begins immediately after the admission, establishing contact with hospital Nurses and Social Workers and maintaining this regularly by phone, email and staffings, and coordinating "doc-to-doc" conferences between inpatient and outpatient	• Continue efforts to educate hospitals, members, and member informal supports about the benefits of involving the ACT team in psychiatric discharges.

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			psychiatrists. The team has face-to-face contact with the member every 72 hours. Discharge planning includes determining where the person will go upon leaving the hospital and submitting housing or placement applications with the RBHA. Staff is present at the time of discharge and transport the member to their residence or desired location. Staff assist members in getting prescriptions filled and obtaining necessary groceries or other necessities. All members are scheduled to see the ACT Psychiatrist within 72 hours of discharge and receive face-to-face contact with staff in the community for five-days following discharge. It appeared from record reviews that members who were inpatient and being psychiatrically discharged were prioritized for face-to-face contact by covering prescribers within the required 72 hours during the 30-day period reviewed.	
O7	Time-unlimited Services	1 – 4 5	Per a review of data provided the reviewers for the last 12 months, the ACT team graduated 20 members to supportive teams. Staff reported that members were graduated when they no longer needed the intensity of ACT services, as evidenced by at least a year of housing stability, involvement in meaningful activities such as employment, no psychiatric hospital admissions or crisis calls, and no involvement with law enforcement. Staff did not believe that graduations were connected with inappropriate admissions to the ACT team, nor had any been recently determined SMI. Staff said discussions about member graduations are usually prompted by an email from agency administration rather than member initiated. Graduation is considered a team goal; step-downs usually take about 30 days with the ACT team facilitating	• ACT teams should graduate no more than 5% of members per year. ACT is not meant to be a short-term program. While it is a worthy goal for ACT members to increase their stability and independence in the community, ACT members often regress when moved to less intensive levels of care.

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			contact with the supportive team for a soft hand-off. When members are uneasy with the idea of graduation, they are given more time to step-down. A crisis or hospitalization may terminate the graduation plan however. Despite the high number of graduations for this review period, staff estimated graduating no more than 5% of members in the next 12 months.	
S1	Community-based Services	1 – 5 4	Staff estimated that 80% of member contacts occur in the community. Staff said that unless they are assigned blue dot coverage for the day they are out in the community. One staff reported that some groups are offered in the community. Members interviewed reported seeing staff in their home and at the office. One member reported coming to the clinic every day. Another described actively seeking contact with staff in order to maintain "the bond" and so that staff will know if they are having any problems. The review of member records showed a median of 63% of member contacts occurred in the community. Most contacts occurred in the context of home visits for medication observation/safety and needs assessment and providing transportation and support at appointments with medical providers. Documentation of home visits appeared in many records in repetitive, template-like form. Some documented community contacts showed staff encouraging members to come to the clinic to attend unspecified groups. Records suggest that when members visited the clinic for groups or appointments some had contact with multiple staff, which contributed to the lower percent of community-based services.	• Continue efforts to deliver 80% of face-to-face services in community settings where challenges and learning are the most likely to occur.
S2	No Drop-out Policy	1 – 5	Staff said that members are generally not closed	

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		5	for lack of contact with the team but are instead placed on navigator status. Less than 5% of members transitioned off the team due to lack of contact with the team. Staff said that they connect members who plan to leave the geographic area with behavioral health services in new communities and will make efforts to connect them with services if they relocate without notifying the team; staff provided three examples of assisting newly relocated members with referrals. Staff said they rarely determine that they are unable to serve members, except in cases requiring a higher level of care such Arizona State Hospital (1), or incarceration for over six months (1). Of the three people who the team determined they could not serve, staff was unable to provide details on one termination. Approximately seven members transferred to other ACT teams, one due to threatening an ACT staff. Several current members are in 24 hour residential treatment and will be transferred off the team after 30 days to avoid duplication of services.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The Reviewers were provided a copy of an *Outreach Process* which spans eight weeks. A designated staff person is assigned to outreach duty. The source of the outreach process was not identified on the written copy provided. The first five weeks direct staff to reach out to "last known phone number/emergency contact/conduct a home visit/Document", to submit non-emergent amendment letter if the member is on court ordered treatment, and to look at the obituaries for the patient. Although not specifically listed on the written outreach process, staff interviewed	• Ensure a formal outreach process is used. • It is suggested that the ACT team use the RBHA's assertive engagement guidelines outlined in the ACT manual, which call for 4 outreach attempts weekly with at least half being in the community and street outreach.

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			said they also visit Central Arizona Shelter Services, jails and hospitals. After the first week of outreach, staff file a missing persons report if on COT and send out certified letters to the last known address. Weeks 6 and 7 direct for that the case is staffed with the clinical team for any engagements; at Week 8, the case is staffed for transfer to the navigation team for continued outreach. One record reviewed lacked evidence of outreach efforts after no contact, while another record showed weekly outreach.	
S4	Intensity of Services	1 – 5 3	Per ten member electronic records, for the period of review, ACT staff provided an average of 53.38 minutes of face-to-face member services per week, with a range of 0 minutes at the low end to 212.8 minutes at the high. Intensity appeared to correlate in many records with frequency of contact. One member received 60 contacts with staff that primarily focused on medication observation and home visit assessment. Rather than offer community based specialty engagement directly related to the member's service plan, the Reviewers found evidence that some staff repeatedly encouraged attendance to generic clinic based groups with no clear connection to individual recovery goals. Several records showed adequate time spent per session, but few contacts for the 30 day period (see Item S5, Frequency of Contact). Three progress notes lacked a record of time spent.	• ACT teams should provide an *average* of two hours or more of face-to-face services per week. This is based on all members across the team; some may need more and some less week to week based on their individual needs. • Focus on delivering community-based contacts that are individualized and geared toward building skills that help the member achieve goals toward his or her unique recovery vision. Avoid over-reliance on clinic based groups.
S5	Frequency of Contact	1 – 5 3	Per member records for the period reviewed, members received an average of 2.63 face-to-face contacts with ACT staff per week. One member received six contacts for the 30 day period reviewed, three members received four contacts each, and one member received zero contacts.	• The ACT team should strive to provide members with an average of four or more contacts per week. Contacts should occur in community settings whenever possible and should be purposeful, person-

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				centered, and recovery oriented. A renewed emphasis on specialty practice may lead to improvement in frequency of contact.
S6	Work with Support System	1 – 5 2	Staff estimates varied 15% - 35% with regard to the percentage of members with a natural support system. One staff member estimated that staff have four contacts monthly with the informal support network for each member with such, though others said that it is usually on an as needed basis and when there is a release of information (ROI) in place. The reviewers were told that some family and friends do not support in ways that benefit recovery but that others are very involved in treatment; some members decline to have ACT staff engage their family or natural support system. Staff reported no training in engaging informal supports in the treatment process. Some members interviewed reported that staff regularly communicate with their family for matters such as help in establishing contact with the member, for feedback on progress, and monitoring needs. In the program meeting observed, it appeared that staff had contact with less than 10% of existing informal support networks. The record review showed less than one contact per month for each member with a support system, occurring in the context of discharge from a care facility, coordination of care, staff leaving a message, and when informal supports happened to be around during home visits.	• Increase contacts with members' informal support systems to four or more contacts per month; regularly revisit with members the benefits of allowing communication between ACT staff and informal supports. • Staff may benefit from training or technical assistance on engaging informal supports to be effective participants in the members' recovery team. • Consider helping members expand their definition of informal supports to consider unpaid helpers other than family such as clergy, neighbors, and member of the peer community, such as relationships at peer-run organizations. • Continue to regularly educate members on the importance of developing and including an informal support system in their treatment, and maintain current ROIs for contact with informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 4	At the time of the review, the ACT team had 49 members identified with a co-occurring disorder (COD). Most members were described as being in pre-contemplative or contemplative change	• The ACT team should provide at least 24 minutes per week of formally structured individual substance abuse treatment

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			stages, though some are in maintenance stage. The Reviewers were told the AC uses the Integrated Dual Disorders Treatment model, and, with most COD members in the early stages of treatment, is focused on engagement, rapport building, and harm reduction strategies. The Reviewers were told that the AC provides about 30 minutes of individual substance abuse treatment to approximately 20 co-occurring diagnosed members weekly, for an average of 12.24 minutes across all members on the COD roster. However, neither data provided to the Reviewers nor the record review could lend support to this report.	across all members diagnosed with a COD. • Fill the vacant SAS position with staff qualified to provide individual substance abuse treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The Reviewers were told that the ACT team provides members with two co-occurring groups weekly, on Tuesday and Friday. The Tuesday group is offered at an ACT community living location and the Friday group is offered at the clinic. The Reviewers were told that groups are open to all clinic members so that while not actively marketed to non-ACT members, a few attendees belong to supportive teams. Although, the AC attempts to follow the IDDT approach in the group, both are open to members at any change stage, so content is adapted to fit those present. Data provided the Reviewers indicated that 24% of members with a COD attended at least one COD treatment group during a 30 day period previous to the review. Data provided showed that six non-ACT team members regularly attended the co-occurring treatment group; in some cases those members made up half to two-thirds of group	• ACT staff should collaborate to increase participation in substance abuse treatment groups to 50% of members with a COD. Prioritize the hiring of a qualified SAS, which may aid in realizing this goal. • Consider structuring groups to target ACT COD members in early and later change stages so that discussions and interventions more relevantly align with their needs and concerns. • It is recommended that ACT co-occurring groups be closed, open only to ACT members whose treatment and support needs may be more complex than those assigned to a lower level of care. ACT SAS time spent providing services to other members, outside of the team, can impact whether SAS staff are fully available to ACT members (i.e., H9, Substance Abuse Specialist on Team).

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			attendance. Data also suggests that some co-occurring groups were provided on days different from what was reported to the Reviewers.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The AC, who has been providing substance abuse treatment with the team for two years, appears well-grounded in the subject. As the primary conduit of substance abuse treatment, the AC was able to well-articulate how stages of change align with specific interventions for a stage-wise approach to COD treatment. The AC currently provides clinical oversight in this area to the other specialists during the Wednesday team meeting. Per the program meeting observed by the Reviewers and staff interviews, staff appeared to recognize the benefits of aligning change stages with appropriate interventions and using harm reduction strategies. It was not clear, however, if all staff offered stage-wise interventions designed to help move members along the change continuum.	• Staff may benefit from shoulder to shoulder mentoring in the field from the AC, and a qualified SAS when hired, in implementing the stage-wise interventions with members at the different stage of change. • Some staff may also benefit from training on utilizing and documenting recovery language that reinforces stage-wise treatment and interventions.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team includes a full-time PSS who carries the same level of responsibility as other specialists. Staff interviewed said that the PSS discloses her lived experience to members when clinically appropriate, although members interviewed were not aware that a peer was on staff with the team. The Reviewers observed the PSS to be a very active contributor to the morning meeting.	• Ensure that ACT members know that the ACT staff includes a person with lived experience who is available to assist them with their treatment goals, offer peer support and encouragement, and serve as a model for recovery.
Total Score:		**3.75**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	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	**105/28=3.75**	
Highest Possible Score	**5**	