ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Kevin Woodbery, Clinical Coordinator

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AHCCCS Fidelity Reviewers

Method

On July 12 – 13, 2016, TJ Eggsware and Karen Voyer-Caravona completed a review of the Southwest Network Osborn Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

Southwest Network serves over 7,600 adults identified with a Serious Mental Illness (SMI) in Maricopa County, Arizona. The Osborn ACT team is housed at the Osborn clinic, located in Phoenix and accessible by public transportation. At the time of the review, the ACT team consisted of ten staff serving 97 individuals, 62 of whom are also identified as having a co-occurring disorder (COD).

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.

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

- Observation of a daily ACT team meeting;
- Individual interview with Team Leader/Clinical Coordinator (CC);
- Group interview with the two Substance Abuse Specialists (SAS);
- Group interview with the Housing Specialist (HS), the Rehabilitation Specialist (RS), and the ACT Specialist (AS);
- Individual interviews with two members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system, with assistance from the Team Leader; and
- Review of the following agency documentation: Osborn ACT Team Pre-Referral Form; Mercy Maricopa Integrated Care ACT Admission Screening Tool; and How Contact Your Team staff phone list.

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.

<u>Summary & Key Recommendations</u>

The agency demonstrated strengths in the following program areas:

- The ACT team meets as a full team four days a week to discuss all ACT members.
- The ACT team is of sufficient size to consistently provide necessary staffing diversity and coverage.
- Since the previous year of review, the ACT team has increased face-to-face, community based services from 20% to 50%, based on a review of ten randomly selected member records. Continued efforts in this area may result in improvements in other areas such as intensity and frequency of services. Also, both the Psychiatrist and Nurse provide services in the community.
- The team seems to be aware of, and responds to, the medical health care needs of the members. Staff noted medical appointments, provided assistance in members attending appointments, and discussed medical treatment provided to the members.

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

- The Osborn ACT team experienced significant staff turnover for the last 24 months, including key staff such as the CC, both SASs, and the Employment Specialist (ES). While the ACT team was nearly fully staffed at the time of the review, most direct services staff lacked sufficient education, training and experience in their respective areas of specialization to fully function in their identified roles or to cross train other ACT case managers. All ACT staff would benefit from targeted training and education in the evidence-based practice (EBP) of ACT, with a focus on aligning positions to the fidelity model.
- The Osborn ACT team does not have full responsibility for treatment services. Aside from case management, the ACT team was found to be responsible for psychiatric and housing services, although evidence was found of delayed processes in helping people find housing. Some members receive substance abuse, employment and counseling/psychotherapy services from outside providers. The ACT team should receive training and mentoring to provide the full spectrum of ACT treatment services, with staff acting in their areas of specialization, and cross-trained to respond to immediate member needs.
- Documentation showed that the ACT team is not fully responsible for 24-hour emergency response but may also direct members in crisis to the crisis line. The ACT team should consistently follow a clear written protocol for the provision of crisis services.
- While the ACT teams appears to prioritize the integration of behavioral and physical health care needs, the observed team meeting, interviews, and member records suggested that the team operates with a more traditional approach focused on psychiatric stability, attendance to appointments, and adherence to medication. The ACT team did not demonstrate a significant commitment to a person-centered, strengths-based recovery philosophy. The ACT team should begin remediating this by:
    - Increase the frequency and intensity of face-to-face member engagement, especially community-based contact where staff can help members build skills, gain insight, and develop resources/natural supports that help sustain community living and recovery.
    - Grow all staff knowledge of the duel disorders model and its application within the EBP of ACT. Staff familiarity and understanding of the co-occurring approach appeared to be inconsistent, incomplete, and at times, misapplied in such areas as

the stages o f change model. Solid grounding in the co-occurring model is especially critical to the provision for substance abuse treatment, both individualized and group.

- Hire a Peer Support Specialist who will further ensure a recovery focus through the continuous recognition and attention to the member perspective and voice.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The member to staff ratio for the Osborn ACT team, excluding the team Psychiatrist, is at approximately 11:1. Two positions were vacant at the time of the review, the Employment Specialist and the Peer Support Specialist.	• The agency should fill the two vacant positions with qualified staff and make efforts to ensure staff retention to maintain a member/staff ratio no greater than 10:1. Appropriate ratios are foundational for adequate service intensity and individualized services.
H2	Team Approach	1 – 5 3	Staff said that the team uses zone coverage, which rotates weekly, to ensure that each staff member engages with all members. The CC reported that 80% of members see more than one ACT staff in a typical two week period. Two members interviewed reported that they had seen four to five different staff members in the last seven days, and said they are case managed by the entire team. A review of ten randomly sampled member records found that 50% of members were seen by more than one staff in a two week period. Staff reported that timely completion of documentation is challenging, which may account for the discrepancy. Scoring on this item, however, reflects the findings of the record review. Many documented encounters appeared to be brief in nature and lacking a clear focus on member needs and goals.	• To ensure that ACT staff know and work with all members, 90% or more of members should have face-to-face contact with more than one staff in any two week period. • The CC should periodically review member records to ensure encounters with members are properly recorded. The ACT team and the agency should collaborate to find solutions to any identified barriers to getting documentation of face-to-face staff/member contacts entered into records on time. • The ACT team should plan encounters focused on needs of members, allowing each staff person to engage members based on their areas of expertise, as appropriate, as well as utilize cross-trained knowledge to avoid delays in service requests.
H3	Program Meeting	1 – 5 5	The ACT team meets four days a week - Monday, Tuesday, Thursday and Friday - for approximately one hour to discuss each member of the team. The doctor currently attends all those meetings, although she mentioned to staff that she may not be able to attend some Friday meetings in the	• Integrate discussion of member goals, status related to those goals, and action plans for the team to assist members to ensure balance of focus for the team meeting.

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			future due to other clinic responsibilities. Observing the morning meeting, the reviewers noted that team culture appeared to be grounded in the more traditional medical model. Most discussion focused on medication and attendance to appointments. There was little discussion of recovery oriented engagement related to housing, vocational pursuits, community integration activities or support networks.	
H4	Practicing ACT Leader	1 – 5 2	The CC said that much of his time is taken up with administrative tasks and meeting requirements, which are an inefficient use of both his and staff's time. The CC identified several technological solutions to mitigating inefficiencies. The CC estimated that 50% of his time is dedicated to direct member service. The review of ten randomly selected member records did not support this, however, finding only two member contacts with the CC that totaled 30 minutes between June 5 and July 5, 2016. Although requested by the reviewers, the CC did not provide a record of actual time spent in face-to-face member services.	• The CC needs to increase direct service to 50% in order to remain connected to members, and to effectively train and mentor other staff in appropriate clinical interventions that follow the ACT model. • The agency should review the CC's administrative duties and clinic activities for opportunities to reassign to other staff, such as the Program Assistant or other managers. • The agency should look at what changes or efficiencies other ACT teams have implemented to increase CC availability to provide direct member services to improve fidelity in this area. • The agency should devise a tracking mechanism through the health record system that will monitor and report actual service time, not billable service time, delivered to ACT members by the CC.
H5	Continuity of Staffing	1 – 5 3	The Osborn ACT team experienced staff turnover at a rate of 54% over the last two years. Nine staff left the team in the 12 months prior to the fidelity review with several leaving after the departure of the previous CC. Four staff joined the team in the	• ACT teams should experience turnover no greater than 20% over a two year period in order to support the therapeutic relationship with members. If not already in place, the agency should consider using a

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			three months prior to the review, with the second SAS joining the team the week before the review. The team has filled ten positions; two positions, the Peer Support Specialist and the Employment Specialist, remain open.	staff satisfaction survey to determine factors that may contribute to high staff turnover. Exit interviews should also be conducted to gather information on reasons why staff leave, and review current policies or establish new policies that support retention.
H6	Staff Capacity	1 – 5 3	In the 12 months preceding the fidelity review there were 40 vacancies on the ACT team, includes five consecutive weeks of time off taken by the team Psychiatrist. The team operated at a capacity rate of 72%. For most of the past year, the team functioned with only one nurse and one SAS. The HS and the RS were brought on in late May and early June respectively for temporary coverage from a supportive team at another Southwest Network clinic. They both formally joined the team as permanent employees the week of the review.	• See recommendations for Item H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 4	The ACT Psychiatrist has been with the team since 2011 and at the clinic since 2008. The CC said that she works closely with team Psychiatrist to guide the team. Staff described the Psychiatrist as a good leader who was accessible to them seven days a week by phone and email. The Psychiatrist conducts home visits every Wednesday with a case manager, and makes herself available to make home visits on other days for members reluctant to come to the clinic. The Psychiatrist is the lead doctor at the clinic and assists with coverage for other doctors there and at other clinics. The Psychiatrist attends a monthly network meeting for the doctors and nurses. These duties take up about eight hours (20%) of the Psychiatrist's time each week.	• Full fidelity to this item requires that the team Psychiatrist's time be devoted 100% to ACT team members and duties. The agency should review the Psychiatrist administrative and coverage responsibilities in order to minimize activities outside of the ACT team. • Arrange for consistent Psychiatrist coverage when the ACT Psychiatrists is on extended leave.

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			The team Psychiatrist had recently returned from a five-week vacation. Multiple agency Psychiatrists provided coverage. Staff reported that some members struggled with change and were reluctant to see Psychiatrists they did not know.	
H8	Nurse on Team	1 – 5 4	After operating with only one Nurse for nine of the last 12 months, the ACT team now has two full-time Nurses. The more senior Nurse has been with the team for about two and a half years. The Nurses provide members with medication education, provide injections and administer medication, and serve as a liaison for the Psychiatrist when needed. Staff reported that the more senior Nurse spends 50% of her time in the community, while the newly hired Nurse currently spends about 10% of her time outside the clinic. The Nurses attend the morning meetings and are available by phone 24 hours a day. The newer Nurse has a caseload of about 10 – 12 members, and 5% of her time is spent assisting the clinic with walk-in members from all of the teams. The more senior Nurse also helps provide nursing coverage for the other teams in the clinic and is the head nurse, supervising all nurses from the other clinics. These responsibilities account for about 25% of her time each week. In the record review, the fidelity reviewers noted multiple instances of non-ACT Nurses dispensing medications and injections to members.	• The ACT Nurses should have 100% of their time assigned to the ACT team and its members. The agency should refrain from assigning the nurse duties that pull them away from being fully accessible to the ACT team in the clinic and in the community. • The team should not consistently rely on other clinic nurses or staff to dispense medications to ACT members since the ACT nurses and their relationships with members play an important role in member engagement, assessment and monitoring.
H9	Substance Abuse Specialist on Team	1 – 5 2	The ACT functioned with a single SAS (1) for eight out of the last 12 months. A second SAS (2) started employment with the team the week prior to the review. Both SASs have limited training and	• The agency and the RBHA should ensure that both SAS receive the necessary education and training to function in their

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			experience in the area of substance abuse treatment, and thus neither is yet in the position to train and mentor the other or the rest of the ACT staff. The more senior SAS (1) has been with the team for seven months. Previous to this position, SAS (1) completed a ten-month internship program doing a chemical dependency group for a master's degree in counseling. The internship did not involved individuals with an SMI. SAS (2) did a six-month internship, split into two different assignments. Although both SASs have internship experience specialized in substance abuse, the populations were primarily general mental health clients.	area of specialization, including cross-training responsibilities. (See Recommendation for Item S9 Dual Disorders Model). The agency should consider providing the SAS with regular supervision by an experienced substance abuse clinician who is knowledgeable about the co-occurring model and its relationship to the evidence-based practice of ACT.
H10	Vocational Specialist on Team	1 – 5 1	The RS and the ES left their positions on the ACT team in March and April 2016, respectively. SWN brought in a Case Manager from a supportive team at another agency clinic to assist the team; that individual was identified in data returned to the reviewers as the ES. The Case Manager elected in early June to accept permanent transfer to the ACT team and was officially hired into the position of Rehabilitation Specialist. The ACT team does not have an ES. The current RS has a degree in a behavioral health related field but does not have specific training and experience in vocational services. He expresses enthusiasm for assisting people in preparing for and attaining employment and described recently helping two members move forward with education and career goals. The RS is communicating with an RS at a supportive clinic in order to develop knowledge and skills in this area. The score for this item reflects the lack of an employment specialist and the RS's lack of training	• The agency should recruit and hire an Employment Specialist with training and experience in vocational services, most significantly assisting people identified with an SMI and/or COD prepare for and attain competitive employment. The ES should have the knowledge and skills necessary to support the training of the newly hired RS, and cross train other members of the ACT team in immediately responding to members who express an interest in obtaining employment. • The agency and the RBHA should provide the RS with specific and ongoing training in the role and responsibilities of vocational services, including how to access pertinent resources such as DB 101 and training related to supported employment. The agency should ensure that the RS is provided multiple opportunities for mentoring by vocational staff from other

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			and experience specific to vocational services. For example, the RS is not yet familiar with DB101.	ACT teams.
H11	Program Size	1 – 5 5	With ten staff serving 97 members, the ACT team is of sufficient size to provide staffing diversity and coverage. The agency provided the team with two case managers from supportive teams to assist with coverage following the departure of several staff in the spring, and they have since joined the team as permanent hires. The team plans to hire two additional staff into vacant positions in the next few months.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team uses the written ACT admission criteria provided by the RBHA. The CC reported that the team has been under no pressure to accept admissions. When referrals are declined by the CC and Psychiatrist, the CC provides a valid reason explaining why the referral was not appropriate for the team. The CC said he prefers not to accept referrals directly from the hospital in order to better assess the individual's appropriateness for ACT and whether or not the person actually wants the intense level of service.	
O2	Intake Rate	1 – 5 5	Since January 2016, the ACT team accepted six new members, with a peak intake rate of four members during February and one member each for March and April.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the ACT team is fully responsible for psychiatric services and housing services. Approximately 3% of members reside in staffed residences where they receive services that overlap with ACT responsibilities. Other members reside in congregate settings with staff, but ACT staff report those staff focus only on maintaining the property, not services. The Housing Specialist (HS) is new to the position and	• The CC, agency, and RBHA should ensure specialists receive education, training and mentoring to support cross training for all staff so that all services can be effectively provided by the ACT team. • Provide the HS with training, education and resources necessary to fully function in that role of assisting members with finding and sustaining tenancy in independent and

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			some evidence was found in the record review of delays in responding to members requesting assistance with finding their own place to live. One member requested assistance with housing, but the team appeared to be more focused on asking the member submit to a drug screen. At one point the member declined to speak with the team further unless it related to housing. Most housing supports documented in the ten member records reviewed were in the form of independent living supports, including budgeting, shopping, nutrition, etc. While staff report 33 members receive individual substance abuse treatment through the team, no evidence of this was found in records reviewed. (See Item S7, Individualized Substance Abuse Treatment). It was unclear from interviews whether or not any members were receiving individual counseling for substance use from other providers. Approximately 13% of members who receive group substance abuse treatment, receive it from outside providers. The ACT team refers members in need of individual counseling/psychotherapy services such as Dialectic Behavioral Therapy (DBT) or Eye Movement and Desensitization Reprocessing therapy (EMDR) to outside providers. In the records reviewed, no evidence was found that members receive individual counseling/psychotherapy through the team. The RS reported providing two members with direct assistance with employment and educational goals; six members receive vocational services through outside providers, primarily work	integrated housing. • Ensure that vocational specialists assist members with rapid access to competitive employment rather than referring to outside vocational services. Collaborate with Vocational Rehabilitation/Rehabilitation Services Administration (VR/RSA) to ensure competitive employment rather than trial work/work adjustment training is the default option. • The team should expand upon current substance abuse treatment, with multiple opportunities for group and individual treatment without relying on outside providers. • The team should provide individual supportive counseling psychotherapy (with the necessary clinical supervision and oversight) for members, and avoid reliance on outside providers other than those who provide treatments outside the scope of staff expertise (i.e., EMDR, DBT).

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			adjustment training.	
O4	Responsibility for Crisis Services	1 – 5 3	According to the CC, the team provides 24-hour crisis services, which all members know about. Members are provided the *How to contact your ACT team* sheet which gives instructions of what to do when in crisis and the phone numbers of all ACT staff (except the team Psychiatrist and the Nurses). The staff names and phone numbers list are updated every few weeks as needed, and the instructions for contacting the team when in crisis is reviewed with members at every clinic appointment with the Psychiatrist or Nurses. According to ACT staff interviewed, when the on-call staff receives calls, he/she assesses for danger to self/others and reviews coping skills with the member. If the individual cannot use the coping skills, the on-call staff will go on-site, calling the mobile team if it is deemed necessary for safety reasons. Usually, if the mobile team is called the CC will also be on-site. Members sometimes call the crisis line if they cannot immediately reach the on-call staff; crisis line staff will re-route the call to the ACT team on-call or directly to the CC. While the protocol for how members should contact staff is documented, it is not clear if the ACT team has a written protocol for staff. Evidence was found in a member record that a member called the on-call staff due to crisis, and the on-call staff made contact with the CC to discuss the situation. The member was then instructed to call the crisis line, or to wake their family to take them to an urgent care facility without an offer from the team to go on-site for assessment and support. No team outreach was noted the following day, and the member was	• The ACT team should consistently be responsible for responding and providing crisis services for members and/or their supports calling for assistance. The ACT team should not redirect crisis response to other providers. • If not already in place, the ACT team should develop a clear written protocol for the provision of crisis services.

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			subsequently hospitalized.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The CC reported that the ACT team had been responsible for 100% of the last 10 hospitalizations. Interviews, however, suggested that the ACT team was involved in most but not all hospital admissions. After reviewing the last hospitalizations with the CC, reviewers found that the data provided was incomplete, and suggested a rate of closer to 75-80%. It did not appear that information for the members most recently hospitalized was provided as requested prior to the review.	• The team should continue to work with members to discuss the pros and cons of informing the team of issues that may lead to hospitalization; attempt to resolves barriers to the team not being involved, including those related to contact between staff and informal supports. • Increasing member engagement through more frequent and intense provision of community-based services may provide ACT staff with more opportunities to assess and provide intervention to reduce psychiatric hospitalizations (See also recommendations for S1, S4, and S5, Community Based Services, Intensity of Services, and Frequency of Services).
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said they were involved in all of the last ten psychiatric hospital discharges, and they are always involved in hospital discharge planning. Staff said they check in with the member within the first few days of hospitalization, have regular contact with the hospital social worker, arrange a “doc-to-doc”, make sure the person has a place to go after discharge, and put in place any recommendations made by the hospital. Staff pick up members from the hospital, pick up prescribed medications, bring members to the clinic to meet with the team Psychiatrist, ensure that members have groceries and necessary personal care items, and take members to their homes. Staff said they visit members every day for the first five days post-discharge, although clear evidence of this was not found in the record review.	
O7	Time-unlimited	1 – 5	Members are ready for graduation upon	• The ACT team should have a discharge rate

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	Services	4	assessment by the Psychiatrist that the member has met certain milestones: medication adherence, appointment attendance, social life improvement, attainment of peer relationships, and the ability to maintain a higher level of functioning. The member should want to be graduated as well. The ACT team expects to graduate about seven (7%) of the 97 current members in the next 12 months, including two in the month following the review.	of no more than five percent (5%) annually. Graduation rates above five percent may suggest members were not appropriately accepted to the team.
S1	Community-based Services	1 – 5 3	Staff estimated that they spend 80% of their time delivering community-based services directly to members. However, the review of ten randomly selected member records found that 50% of services were delivered in the community. Some staff documented significantly more community-based services than others, possibly due to differences in how clearly service delivery location was noted or due to difficulties in entering timely service notes. Staff reported providing some group services other than substance abuse treatment in the clinic. Groups provided in the clinic included art and coping skills. ACT staff also rotate sitting at a desk in the main entryway. It appears the function of this role is as greeter and liaison to other clinic staff supports. It is not clear to what extent this added duty prevents ACT staff from delivering community-based services.	• ACT direct service staff should increase community-based services to 80%. The agency and the team should collaborate to explore current barriers to achieving this. Technology based solutions may be considered, as well as staff mentoring in the community by the CC. • The team should discontinue providing clinic based groups other than substance abuse treatment groups. The evidence-based practice of ACT services is designed to be community rather than clinic based in order to help members gain new knowledge and skills in behaviors, problem solving, and symptom management in locations where they are most likely to have challenges. Community-based services allow staff to assess needs, monitor progress, model desired learning, assist in identifying and using resources and natural support, and provide encouragement. • Ensure the duties of ACT staff align with the model. Seek to eliminate other functions, implemented by the agency, that are not

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				explicitly required in the model.
S2	No Drop-out Policy	1 – 5 5	For the period under review, of 97 members, the ACT team had a drop out rate of two percent (2%); one member due to lack of engagement/refusal of services, and one who left the geographic area without a referral.	
S3	Assertive Engagement Mechanisms	1 – 5 3	The CC did not articulate a formal, structured outreach plan, and the team's use of assertive engagement strategies was difficult to capture from the morning meeting observed by the reviewers. Although requested, a written copy of an outreach plan was not provided. The CC said the team uses an outreach process as instructed by the team Psychiatrist and the Clinical Director. Outreach occurs immediately when a member misses an injection or doctor appointment. Staff conduct daily outreach activities for the first week, every other day for the second week, daily the third week, every other day the fourth week, and so on until the team makes contact with the member. . Outreach may continue for a couple of months if directed by the Psychiatrist. Outreach begins with follow up with payees, probation officers, family members, and other members with whom the individual associates, followed by check-ins with jail, the morgue, and finally hospitals. Rather than going by a checklist, a Notice of Action is sent to the member based on what the team sees in the progress notes. This approach could be problematic: in some records reviewed, community-based outreach was not documented before calls to the jail or morgue, which sometimes occurred within a week of a member's last contact with the team. In one example staff were informed a member spent time at another clinic operated by the agency, but it	• If not already developed, the team should create a clear protocol and timetable for making contact and engaging members who need outreach. The protocol should make use of the member's formal and informal support network, as well as street outreach in areas where the member is known to frequent.

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			was not clear if ACT staff attempted to outreach the member at the other clinic location.	
S4	Intensity of Services	1 – 5 2	The review of ten randomly selected member records showed an average service time per week of close to 40 minutes per member. Service times ranged from a low of less than eight minutes per week to a high of 94.25 minutes; five members received less than 37 minutes on average per week. The reviewers found numerous instances of medications being dispensed to members by nurses not assigned to the ACT team. The reviewers also found repeated instances of staff delaying response to member requests by referring them to other staff specialists. The reviewers noted many member contacts in the clinic that appeared to be brief, general greetings or exchanges following visits with the Nurse or Psychiatrist, with little engagement focused on recovery goals.	• Increase average direct service time to members to at least two per week. Direct service contacts should be face-to-face and occur primarily in the community. • Decrease reliance on services provided by outside agencies and/or staff not assigned to the ACT team, and empower staff to function fully within their areas of specialization. Ensure that specialists provide cross-training to each other to respond immediately to members' stated needs. See also recommendations for O3, Full Responsibility for Treatment Services.
S5	Frequency of Contact	1 – 5 2	The review of ten member records found the median face-to-face staff contacts with members to be 1.5 contacts per week; five members received 1.25 contacts or less per week on average. Staff reported high staff turnover, time	• The agency should work toward maintaining full staffing; new staff should be trained on the benefits of high frequency of member contacts, with the goal of at least an average of four member

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			spent in administrative tasks such as clinic meetings, responding to email, and completing documentation as barriers to spending time directly serving member needs. Some agency staff face-to-face contacts with members could not be counted for this item because they were not delivered by the ACT team. Some ACT staff facilitate groups open to all members of the clinic. It is not clear how much of their time is spent providing, or documenting services for non-ACT members, or if these duties impact the frequency of contact with ACT members and their ability to fulfill other ACT roles.	face-to-face contacts per week, per member. • Decrease use of agency staff not assigned to the ACT team; ensure ACT staff are not pulled to perform other clinic coverage duties. • Decrease ACT staff time spent providing services to non-ACT members.
S6	Work with Support System	1 – 5 2	Staff interviewed reported considerable variation in the number of members who had an informal support system, from 50% to 100%. One staff member said that for the 50% of members who had an informal support system, staff have had at least one contact with them in the last month, usually weekly. Another staff person said that staff had at least one contact with 100% of members' informal supports in the last month. Based on the record review, staff were found to have an average of 1.40 contacts with each member's informal support system per month. Due to the limited number of members who agreed to participate in interviews during the review, the reviewers were unable to confirm with members that the team works consistently with informal support systems. The reviewers noted little mention on informal supports during the team meeting they observed. During the morning meeting a staff reported they did not have a release to speak with the family of one member, but a SWN administrator who was present informed them that certain information can be	• The team should encourage members to identify natural and informal supports and discuss with them the benefits of involving them in their treatment. • Staff should seek to obtain signed member Release of Information forms when they identify informal supports, so that they can be engaged to provide psychoeducation, obtain feedback, assist in monitoring needs and concerns, and support intervention if the member is near or in crisis. • Review confidentiality guidelines with staff so they know what information they can share with, or receive from, informal supports. • Proactively, engage informal supports on average four times monthly as partners in support of recovery goals. • The CC should work with staff to document contacts with informal supports to help make records more consistent with service provision.

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			obtained from family even without a release from the member.	
S7	Individualized Substance Abuse Treatment	1 – 5 2	According to the CC, 62 (64%) of the 97 ACT members have been identified as having a co-occurring disorder. The SAS (1) reported that 33 (53%) of those 62 members participate in structured, individual substance abuse counseling per month. Sessions usually occur in members' homes and last 20 minutes to one hour. The SAS (1) said that she sees between 15 – 20 members for an average of 40 minutes in individual substance abuse counseling each week. Some members are seen a couple of times a week, some every other week. This averages to less than six minutes of individual substance abuse counseling weekly for all 62 members with a co-occurring disorder. The SAS (1) said she uses a mental health and substance abuse perspective to help members develop coping skills and learn different ways to manage symptoms, via harm reduction tactics. When asked, the SAS (1) did not identify specific examples of interventions used with members. In ten member records examined, the reviewers did not find any instances of the SAS (1) providing structured or individualized treatment to members with a co-occurring diagnosis. At the time of the review, the SAS (2) had not yet officially started contact with members.	• The CC and the agency should ensure that the SASs receive the necessary training, mentoring, and supervision to provide structured, individual substance abuse counseling to members identified with a co-occurring disorder. • The CC and the agency should collaborate with the SASs to resolve any barriers to timely documentation of individual substance abuse treatment, so there is more accurate tracking of treatment that is occurring. • Monitor member participation in individualized substance abuse treatment through the SASs. Review documentation of individualized treatment during supervision with SASs to ensure services align with the members' stages of change.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SAS (1) facilitates one substance abuse specific group per week. In the month prior to review, the SAS (1) estimated that about 20 (32%) of the 62 ACT members with a co-occurring disorder attended. The group meets four times a month for one hour. Three to ten ACT members attend each week, with three members in attendance consistently each week. The group is open to all	• If not already in place, the agency and RBHA should ensure ongoing training and education for the ACT team, and the SASs in particular, on following the established, stage-wise curriculum, such as Integrated Dual Disorders Treatment (IDDT). • The ACT team should expand substance

Item #	Item	Rating	Rating Rationale	Recommendations
			members of the clinic, although it is primarily attended by ACT members; the SAS (1) does not actively promote the group outside the team. The agency provides a "Groups to Go" curriculum for the substance abuse group; it was not clear who developed the curriculum or what model it follows. The SAS (1) said she uses the curriculum but also supplements it with activities for members who are lesser functioning. The SAS (1) said she provides activities focused on self-care, coping skills, increasing self-awareness, and problem solving.	abuse treatment group options for members, along with outreach efforts to increase attendance to at least 50% of members with an identified co-occurring disorder. • The agency and the RBHA should seek consultation to establish whether or not the "Groups to Go" curriculum aligns with the IDDT approach and make any adjustments necessary.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 2	Per the CC interview, the team follows the Integrated Dual Disorders Treatment model. The CC described the goal of substance abuse treatment as one of constant recovery; abstinence may be an ultimate goal. The CC said that use harm reduction tactics that celebrate steps toward reducing use as progress. The CC said the team also uses the stages of change model, with perhaps 70% of members in pre-contemplation, 10% contemplation, and 10% maintenance stages. The SAS (1) said she refers members to Alcoholics Anonymous/Narcotics Anonymous (AA/NA) if it meets their needs and is appropriate for them (i.e., the member can tolerate group without worsening symptoms such as anxiety and paranoia) or will aid in building social skills. The SAS (1) said that the team refers members to detox when medically necessary, such as when alcohol, benzodiazepines, barbiturates are life threatening. The SAS (1) said some members want help getting off heroin, and the Psychiatrist may refer to detox for this.	• The agency and the RBHA should provide the team training and guidance on the IDDT model. This should include specific training targeting the SASs, both relatively inexperienced prior to their employment on the ACT team with the adult SMI/COD population, in order that they are prepared to provide critical cross training to other and future ACT specialists. • Shadowing and mentoring by the CC in order to provide guidance and modeling of interventions may also be beneficial, as well as regular networking and peer group supervision with other ACT SASs.

Item #	Item	Rating	Rating Rationale	Recommendations
			Knowledge of the IDDT approach across the team was uneven. Some staff viewed abstinence as the primary goal, while others described a focus on harm reduction through focus on small, reachable goals. In documentation, there were multiple examples of staff assessing a member's stage of change based on whether they interacted or responded to that staff, and not on the member's motivation to make a change in their substance use. For example, a member was not home when a CM went to visit and it was noted the member was pre-contemplative as evidenced by not engaging with the team. Although some staff could identify interventions such as motivational interviewing, it was unclear if all staff understood how to apply stage-wise treatment approaches to corresponding stages of change.	
S10	Role of Consumers on Treatment Team	1 – 5 1	Documentation found in member records suggested the immediate past PSS functioned as an equal member of the team, and this was confirmed in staff interviews. At the time of the review the ACT team did not have a Peer Support Specialist; this is reflected in the score.	• Hire a qualified PSS to the ACT team to provide a voice and perspective of lived experience of disability and recovery to member services.
	Total Score:	**3.21**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	1
Total Score	**3.21**	
Highest Possible Score	**5**	