ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 4, 2018

To: Laura Larson-Huffaker, Chief Executive Office

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AHCCCS Fidelity Reviewers

Method

On April 3 – 4, 2018, Karen Voyer-Caravona and Annette Robertson completed a review of the LaFrontera-EMPACT Tempe 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.

LaFrontera-EMPACT provides behavioral health services to children, adults, and families. Outpatient and inpatient services are available and include: counseling, psychiatric services, substance abuse treatment, trauma healing, crisis intervention, supportive services, and services for adults with a serious mental illness (SMI). LaFrontera-EMPACT currently has three ACT teams: two in Phoenix, Comunidad and Capitol (located in the same clinic), and the Tempe team. In addition to behavioral health services, the Tempe team also offers members with the option of on-site primary medical care.

The individuals served through the agency are referred to as "member"; 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:

- Observation of a daily ACT team meeting on Tuesday, April 3, 2018;
- Individual interview with Tempe clinic ACT Manager;
- Group interviews with the two Substance Abuse Specialists (SAS);
- Individual interviews with the Peer Support Specialist (PSS) and the Employment Specialist (ES);
- Group interview with five members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- A review of agency provided material including: ACT Eligibility Screening Tool (LaFrontera-EMPACT ACT Operating Protocol), *Master Schedule - Tempe ACT Team,* resumes and training transcripts for the two SASs, the ES, and the Rehabilitation Specialist (RS); individual substance abuse treatment encounter reports for the SASs; co-occurring group sign-in sheets for two months previous to the review;

LaFrontera Tempe ACT Team Contact Information sheet; on-call calendars for January, February, and March 2018; *Tempe ACT Brochure*; flyers for three groups offered to members and one group offered to informal supports: Dialectic Behavioral Therapy (DBT), Seeking Safety, Early Recovery, and Family and Friends; *Tempe ACT Group Calendar*, *Inpatient Coordination of Care* form, and the *Tempe ACT Team Outreach and Engagement Strategy*.

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:

- ACT Psychiatrist: The ACT Psychiatrist is fully dedicated to the ACT team for 40 hours per week and described by staff as a team leader who is accessible to staff after hours and on weekends when the need arises. Staff reported the ACT Psychiatrist is exceptionally thorough in reviewing clinical records when screening potential ACT members.
- Substance Abuse Specialists on the team: The ACT team has two highly motivated SASs with the training and experience to provide group and individual substance abuse treatment to members diagnosed with a co-occurring disorder, as well as to cross train other team specialists.
- Vocational Specialists: The ACT team is served by an ES and RS who have relevant training and experience in assisting people with disabilities find and retain competitive employment.
- Co-occurring model: Staff interviewed demonstrated knowledge of and embracement of the co-occurring model; staff described acceptance of various levels of readiness to change patterns of substance use, and were able to describe specific examples of how the team applies interventions that align with members according to their stage of change.

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

- Practicing team leader: At the time of the review, a new Team Leader/Clinical Coordinator had been with the team for approximately two weeks and had only just begun providing direct member services. The ACT Manager had been covering the position for approximately five months, but had not been providing direct member care. The CC should spend 50% of his time devoted to providing face-to-face member services, which may include shadowing and supervising team specialists in the delivery of ACT services.
- Nurse on the team: The 80 member ACT team is served by one full-time Nurse. Although a Family Nurse Practitioner (FNP) who serves as the team primary care provider (PCP) provides unscheduled nursing support when needed, some staff interviewed said that members would benefit from a second Nurse. The team should have two full-time nurses to ensure care is delivered both in the clinic and in the community; this will be especially important as the team reaches membership capacity.
- Intensity and frequency of services: Per a review of ten member records, on a weekly basis, ACT members receive an average of about

50 minutes of face-to-face contact with an average of two contacts. ACT staff should provide an average of 2 hours of face-to-face contact with an average of 4 times weekly for each member, with continued present efforts to deliver most of those services in the community where challenges are best observed and monitored, and solutions found.

- Work with support system: Staff interviewed stated that collaboration with informal supports is a necessary feature of service provision; however, a review of ten member records found less than one contact per month, per member. Though in the program meeting observed by the reviewers, staff mentioned members' informal supports, the reviewers generally did not hear how they were engaged or a plan for engagement. The ACT team should have four monthly contacts documented for each member with a community support system.
- Co-occurring treatment groups: Though the team offers two co-occurring groups weekly, only 29% of the team's 55 members identified with a co-occurring disorder (COD) had attended at least one group in the month preceding the review. The ACT team should increase attendance to 50% of members identified with a COD; the CC and SASs should work with the rest of the team to engage members in the benefits of participating in group treatment.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team consists of 11 staff serving 80 members. The identified staff on the ACT team are: a Team Leader/Clinical Coordinator (CC), a Psychiatrist, a Nurse, two Substance Abuse Specialists (SAS), a Housing Specialist (HS), an Employment Specialist (ES), a Rehabilitation Specialist (RS), a Peer Support Specialist (PSS), an Independent Living Specialist (ILS), and an Act Specialist (AS). Although the team also has a Family Nurse Practitioner serving as the team's Primary Care Provider (PCP), that position is not required in the SAMHSA fidelity protocol for ACT. Excluding the Psychiatrist and the PCP, the member to staff ratio is 8:1.	
H2	Team Approach	1 – 5 4	Staff interviewed estimated that at least 90% of members see more than one staff in a two week period. Staff said that in the last three months the team instituted East/West coverage zones that are covered by two teams of three staff. Each team covers either the East or the West side of the Phoenix metropolitan area for two weeks at a time, and then the teams switch sides. Staff has been empowered to work together to ensure that all members who need face-to-face or phone contact (i.e., hospitalization, medication observations) are seen. Staff reported they believe this new plan is helping them meet coverage goals. Members have appointment calendars, which note groups, scheduled meetings with staff, and other activities; staff keep copies of the calendar which is updated daily in the morning meeting and is tracked by the CC and ACT Manager. However, per a sample of ten randomly selected member records, only 70% of members saw more than one	• The ACT team should ensure that 90% or more of members receive face-to-face contact with more than one staff every two weeks; monitor newly implemented East/West coverage zones for effectiveness and revise as needed.

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			direct service staff during a two week period.	
H3	Program Meeting	1 – 5 5	The ACT team meets four days (M, T, Th, F) a week from 10AM – 11AM for a program meeting in which all 80 members are discussed. Most staff work four, ten hour days and attend the meetings on the days they are scheduled to work, unless they have immediate member needs to be addressed at that time, such as mental health court or a hospital discharge. On Wednesdays, the team meets for trainings and to staff specific members, such as those approaching crisis or on outreach. At the program meeting observed by the reviewers, the meeting was led by the ACT Manager due to the CC attending a member's psychiatric hospital discharge; it was reported that the ACT Psychiatrist was seeing a member, thus was also absent. All members of the team were discussed. Staff identified contacts and services provided for each. Staff updated the team on status of housing, employment and other meaningful activities, and upcoming appointments, including those with medical specialists and the court system.	
H4	Practicing ACT Leader	1 – 5 1	The CC position had been vacant for several months until the end of February when the new CC was hired. It was reported that the CC began new employee training upon hire and did not assume duty until March 12, 2018 and only recently began providing direct service, thus a meaningful encounter report could not be provided. The ACT Manager, who had been covering for the team, reported that she did not provide direct member services.	• The CC should spend 50% of his time providing direct care to members. Most of this time should be delivered in the community, and should include mentoring and shadowing specialists. • Ensure the new CC is trained and provided the clinical oversight and support to be retained in the position in order to build rapport and relationships with members and effectively mentor/support specialists in the delivery of community based services.

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H5	Continuity of Staffing	1 – 5 2	The ACT team experienced a turnover rate of 68% for the previous 24 months. Per data provided to the reviewers, 15 staff left the team during the 24 months preceding the review, including a staff serving in the ILS position who shifted to the Program Assistant (PA) position to provide extended coverage while that staff was on leave. Per data provided and staff interviews, the CC position turned over three times during that period. Additionally, the Nurse position has turned over four times. One staff person interviewed expressed the view that a past Nurse was overwhelmed in the position. Some members expressed concern about staff leaving the team.	• Identify and find solutions to any barriers to a turnover rate of no more than 20% in two years. • Incentivize staff retention through training and mentoring that supports professional developments in their areas of specialization. • When recruiting for staff positions, the agency should vet candidates as much as possible and ensure new hires have a full understanding of the demanding role of working on an ACT team.
H6	Staff Capacity	1 – 5 5	The sum total of staff vacancies for the 12 months preceding the review was six for a capacity rate of 96%. The CC position stayed open five months but was covered by the ACT Manager, while the Nurse position stayed open two months. At the time of the review, staff reported that some roles had temporarily shifted to accommodate extended leave for the team's PA. Because the PA was described as critical in supporting the Psychiatrist, the ILS, who had previous PA experience, was assigned to cover that position, while the current AS was likewise shifted temporarily to the ILS position. The team then elected to hire additional staff to cover that position. No staff were on leave for a month or longer during the 12 months reviewed.	• See recommendation for H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The team has a fully dedicated Psychiatrist who is scheduled 40 hours weekly and works four, ten hour shifts (M, Tu, Th, F). Staff described the Psychiatrist's role as that of a leader and educator, providing specialists with information on symptoms, psychiatric medications, and side-	

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			effects. The Psychiatrist regularly updates staff in the program meeting and by email on previously undisclosed information derived from members such as newly arisen needs. It was reported that the Psychiatrist conducts home visits one Friday a month for members who have more complicated medical issues. Staff said that the Psychiatrist attends two to four program meetings a week and is accessible to them after hours and on weekends. Staff reported that the CC or the ACT Manager usually act as a liaison between specialists and the Psychiatrist, but that they all have her mobile phone number and can contact her directly if the situation requires. One staff said that the Psychiatrist may see general mental health members at another clinic on Wednesdays, outside her scheduled 40 hours.	
H8	Nurse on Team	1 – 5 4	The ACT team has one Nurse serving the 80 member team. The Nurse provides injections, prepares medication sets, dispenses medication to members and provides them with medication education, draws blood, coordinates with the pharmacy, coordinates with inpatient hospitals regarding medication, and does occasional home visits with difficult to engage members. The Nurse works full-time, for four, ten hour days during the week and attends program meetings on Mondays, Tuesdays and Thursdays. The Nurse is accessible directly to specialists by phone and text message. The Nurse has no other responsibilities other than the ACT team. Supporting the agency's goals to provide integrated care, the team also has an FNP whose primary responsibility is that of the team's PCP. It	• The FNP does not replace a full-time Nurse. A second full-time Nurse is recommended to support members' psychiatric needs. Ideally, two nurses would coordinate their time to provide services to members within both the clinic and the community. This will be particularly important as the team moves closer to full member capacity.

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			was reported that the FNP supports the Nurse position on Fridays on an as needed basis for unscheduled visits by members who missed appointments earlier in the week. Also, some staff also said they usually contact the FNP on weekends and evenings if they have a question or concern they would normally direct to the Nurse. The reviewers saw no evidence of how the FNP supports the Nurse in member records.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has two SASs with training and experience in co-occurring disorders treatment. SAS1 has a Master in Educational Counseling degree and is a Licensed Professional Counselor (current and active per Arizona Board of Behavioral Health Examiners). SAS1 has been in the position a year and a half, starting with the agency in 2012 at another clinic where she provided behavioral health services to both general mental health and SMI determined members. Training transcripts show courses completed between 2009 and 2017 in substance abuse treatment including: biopsychosocial model of addictions, women and substance abuse, Integrated Dual Disorder Treatment, and integrated treatment in co-occurring disorders (COD). In addition, SAS1 has completed numerous advanced trainings in evidenced based practices relevant to the co-occurring population. SAS2 has been in the position since February 2018 but on the team in another position since December 2016 when she received cross training in co-occurring treatment. Training transcripts for SAS2 show two Relias courses completed in co-occurring treatment in early 2017, but no recent training. SAS2's resume indicates that she worked	• Ensure on-going training in co-occurring treatment for the SAS2 to enable cross training to other specialists and support her skills in formal substance use counseling.

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			for over a year as a Behavioral Health Technician at Mercy Integrated Health Systems facilitating daily inpatient substance abuse education and relapse prevention groups, as well as informal counseling, to individuals under court ordered evaluation and/or court ordered treatment. Clinical oversight for the SAS2 is provided by the ACT Manager, who is an LPC, as well as the SAS1. The SAS1 consults peer to peer as needed with the ACT Manager regarding cases.	
H10	Vocational Specialist on Team	1 – 5 5	The ACT team has two vocational staff: an ES, who has been with the team about seven months, and an RS, who has been with the team for 14 months. The ES came to the position with several years of experience as an employment coach with another agency serving the SMI population, creating partnerships with community employers. In that capacity, the ES completed 15 hours of training for certification by Boston University in job development and placement. Additionally, the ES is certified in S.O.A.R. (Social Security Income/Social Security Disability Insurance Outreach, Access, and Recovery). The RS originally joined the team as the ES before transitioning to the RS role about seven months ago when the current ES was hired. The RS has worked in behavioral health in numerous capacities, including as a Job Developer with a Supported Employment Program, and for another network provider as an ACT ES. Per report, the vocational staff are assisting 10 – 12 members to find employment, including resume building and job search.	
H11	Program Size	1 – 5	With 11 staff, including the ACT Psychiatrist, but	

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		5	excluding the FNP, the ACT team is of sufficient size and diversity of specialty to serve a maximum capacity of 100 members.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team uses an explicit written admission policy modeled after that developed by the Regional Behavioral Health Authority (RHBA). Staff said the form was revised to include questions pertinent to physical health issues, as per the team's provision for primary care; although this appears to be for information gathering purposes only, rather than to divert from ACT's admission criteria. It was reported that all staff are trained to conduct screenings. Staff said that previously the team had been pressured to accept referrals (usually individuals who had recently been determined SMI and had not yet been serviced by lower levels of care). However, staff reported the current ACT Psychiatrist reads all referrals and accompanying documentation thoroughly to ensure appropriate admissions.	• Continue efforts to carefully screen referrals to ensure that only those members who meet the explicit ACT criteria and understand the intensity of services provided are admitted to the team.
O2	Intake Rate	1 – 5 5	In the six months previous to the review, the ACT team has admitted nine members. The greatest number of admissions, three (3), occurred in January 2018.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management services, the ACT team is fully responsible for psychiatric services and substance abuse treatment. The team also provides most counseling/psychotherapy, employment and rehabilitative services. All members are seen by the Psychiatrist; one member who recently stated a preference for an off-team Psychiatrist is transitioning to a supportive level of care treatment team. The SAS1, who is an LPC, sees several members for	• As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team.

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			individual counseling/psychotherapy that emphasizes solution focused brief treatment, cognitive behavioral techniques, and trauma informed approaches. One member is seeing an off-team therapist specializing in eating disorders. The vocational staff are working with approximately 10 – 12 members on finding competitive work, and it was reported that about eight members are currently competitively employed. Although it was reported that the team does not refer to external employment services providers, one member is being seen by an outside agency for work adjustment training at the direction of the member's guardian. Although it was clear from documentation that the team provides housing support and assists members in locating housing, full credit in this area could not be given because over 10% of members live in staffed or semi-staffed settings where they receive some level of support. Staff noted that three members currently residing in 24 hour residential settings, are planning to transition to supportive care.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team has full responsibility for crisis services. The ACT team has an on-call system which rotates daily between staff. Members are educated to call the on-call during crisis and are given the *LaFrontera-EMPACT Tempe ACT Team Contact Information* flyer at intake, which has the on-call number, the CC's mobile phone number, and the daytime numbers for the Psychiatrist, Nurse and PCP. Additionally, members receive Tempe ACT business cards with all staff phone numbers printed on the back. On-call begins at 4PM and ends at 7AM weekdays. During the day,	

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			the on-call phone number is answered by the CC or the ACT Manager. On-call over the weekend is 24 hours, from 7AM – 7PM. The new CC is currently the back-up and is covered by the ACT Manager, if unavailable.	
O5	Responsibility for Hospital Admissions	1 – 5 5	Staff interviewed said the team seeks to minimize hospitalizations by assessing symptoms and signs of emerging crisis, safety planning with members who express self-harm thoughts and plans, and attempting to use diversion strategies to maintain the individual in the community. When this fails, the Psychiatrist may determine that a psychiatric hospitalization is warranted, and the member will usually be referred to the nearest facility. Members, who refuse admission, may be petitioned or have court orders amended; upon location by law enforcement, the member will be transported to an urgent psychiatric center for evaluation. Per a review with the ACT Manager of data submitted to the reviewers, the ACT team was involved in 100% of the ten most recent psychiatric hospitalizations. The team coordinated with staff at members' residences and a guardian in two admissions. Staff responded in person to calls from spouses of members who were in crisis and verbalizing danger to self and others (the spouses). In one instance, a member's husband contacted the team to alert them that he was on his way to the nearest emergency room with the member. The team met the member at the emergency room, stayed with her, filed an amendment for DTS/DTO and arranged for transfer to a psychiatric hospital. Four members were picked up by the police after the team filed	

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			amendments for DTS/DTO.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff said they usually are involved in all psychiatric hospital discharges, often in coordination with families and guardians. Discharge planning begins at admission when ACT staff make contact with the inpatient Social Workers and Psychiatrists, arranging doctor to doctor communication, providing medication sheets, and discussing plans for aftercare, including housing. Staff reported they developed a *Coordination of Care* form they now take with them to admissions, as well as updated versions whenever they visit the hospitalized member, and that inpatient staff have found it helpful. ACT staff visit members within 24 hours of admission and then every 72 hours. When a discharge date has been set, staff attend and then assist members in collecting new medications, and other items as needed, prior to transporting them to their home or where they have decided to stay. The ACT Psychiatrist and Nurse, as well as the PCP if assigned, are scheduled to see the member within 72 hours of discharge, and staff are to have face-to-face contact with the members for five days. Per a review with the ACT Manager, the ACT team was directly involved with 80% of the last ten psychiatric discharges through March 14, 2018. In one instance, staff described coordination with a spouse who wanted to transport the member home, and documentation verifying team assistance in the discharge was not found in the member record randomly selected for review. In another case, although the ACT team had coordinated with a spouse to assist with a member's discharge, when the team arrived at the	• In order to achieve a goal of 95% or more ACT team direct involvement in psychiatric hospital discharges, the ACT team should continue educating inpatient teams and informal supports on the importance of coordinating with the ACT team to be present at all discharges.

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			hospital they learned that the member had already been discharged into the spouse's care. Per interview, some psychiatric hospitals still discharge members without alerting the ACT team.	
O7	Time-unlimited Services	1 – 5 4	In the past 12 months, the team has graduated 11 members from the team because of significant progress. It was noted that previously some individuals newly determined to have an SMI diagnosis were admitted to the team under pressure from other entities, especially psychiatric hospitals. Along with more rigorous review of referral documentation on the part of the Psychiatrist, the ACT team is now trying to include the referring inpatient Social Workers in screenings, and conducts educational presentations on ACT services to system partners. The ACT Manager reported that the team anticipates graduating about 6 (7.5%) members in the next 12 months.	• Because individuals who meet ACT criteria tend to regress at lower levels of care, it is expected that ACT members receive time unlimited services; ACT teams should graduate fewer than 5% of membership annually. • See Recommendation O1, Explicit Admission Criteria.
S1	Community-based Services	1 – 5 4	Though staff interviewed reported that 80% or more of member contacts occur in the community, the record review showed that services took place in the community 65% of the time, usually during home visits. Members interviewed said that they usually see ACT staff at their home or the office, or other places they may be such as peer run programs. One member stated home visits are preferable because traveling the distance between home and the clinic is stressful.	• Continue efforts to have face-to-face member contacts in the community 80% or more of the time, in order to effectively monitor member progress in independent community living and model desired skills and behaviors. These efforts can effectively reduce hospitalizations and members crisis events.
S2	No Drop-out Policy	1 – 5 4	The ACT team retained 94% of membership in the last year. Five members left the team during the 12 months previous to the review. No members left the team because they could not be served. Two refused ACT services after numerous staff attempts to engage in treatment. Two members	• The ACT team should retain 95% of caseload over a 12-month period. See recommendation for Item O1 Explicit Admission Criteria.

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			left the area without a referral and the team did not have their exact location. One member could not be located and outreach to a sibling in a neighboring state yielded no information on the member's whereabouts. Limited information was provided about these five members, but staff interviewed said that some of those members were very new to the team, joined the team without sufficiently understanding the intensity of services, and/or may not have been appropriately referred. Staff said the current Psychiatrist is more actively involved in screening referrals to ensure proper fit with the team. Three members who were determined to require residential treatment moved to another level of care to avoid duplication of services. Two members relocated out of state and were assisted by ACT staff with referrals for continued treatment. One member who could not be found during outreach was moved to navigator status. Two members left the team to serve prison sentences; one of those members who was released early re-enrolled with the team and has been very engaged in services since.	
S3	Assertive Engagement Mechanisms	5	Staff provided the reviewers with a copy of their *Tempe Act Team Outreach and Engagement* protocol. Although the protocol does not specify how long a member must be out of contact, members are placed on outreach status when the team is unable to locate or contact them; the outreach is assigned a specialist who is responsible for conducting and documenting outreach. Four outreach attempts are made weekly for eight weeks. Three attempts may be by phone and can include contact with family, emergency contacts,	• Ideally, outreach is should be carried out by multiple ACT staff with whom the member has existing relationships.

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			jails, hospitals or payee services. One weekly outreach attempt must be in the community, including jails, shelters, and last known residence. Per protocol, if after eight weeks the member is not located, the matter is staffed with the ACT Manager and Psychiatrist to discuss closure from the ACT team or further outreach. Member cases are not closed from the RBHA, but transitioned to the agency Navigator status, unless they are incarcerated for over three months, move out of state with coordination from the team, have transitioned to Arizona Long Term Care System (ALTCS), requested decertification from SMI status, or have died. Staff interviewed were able to relate the protocol to the reviewers. The record review and review of inpatient admissions showed that the team will use legal mechanisms when necessary to keep members engaged. Documentation of outreach may be inconsistent. One record reviewed showed a member on outreach but only between one and three outreach attempts documented weekly, with few details. However, in one instance outreach was performed at Central Arizona Shelter Services (CASS) by a specialist who was new to the team and had not yet developed a relationship with or known to the member.	
S4	Intensity of Services	1 – 5 3	Per the review of ten member records, members received an average of 50.38 minutes of contact weekly. Averages ranged from a low of 6.25 in one record to a high of just over 412 minutes in another. Many community based contacts included 5 to 15 minutes spent in medication observation and education. Other time spent included: providing counseling/psychotherapy, helping a member process feelings and concerns	• The ACT team should provide an average of at least two hours a week of face to face contact for each member served, preferably delivered in the community focused on member's identified recovery goals. • Ensure that all contacts are documented in a timely manner.

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			about pending medical procedures, supporting a member awaiting sentencing following criminal convictions, and helping a member manage interactions with neighbors in the apartment complex.	
S5	Frequency of Contact	1 – 5 3	Staff reported that their contact goals are to see each member a minimum of four times weekly. Per the record review, members averaged two contacts with ACT staff weekly. Most members interviewed said they had seen one or two different ACT staff during the last week, either at their home or in the office.	• ACT staff should provide an average of four or more face-to-face contacts with members. The number of contacts may vary across the membership, with some members receiving fewer and others receiving significantly more depending on immediate and emerging needs.
S6	Work with Support System	1 – 5 2	Most members interviewed reported that they had some type of informal support system, usually a family member, and that the ACT team had periodic contact with them often during home visits. Some members said that staff has occasional contact with family supports who live out of state. Members reported that they believe it is helpful for staff to have contact with their family. Staff reported varying estimates of the number of members with a support system, from 30% to 75%. Staff said they have at least one monthly contact with a support for each member that has one. The PSS facilitates a weekly Friends and Family group for members' supports, but attendance is rarely above three. Although, in the program meeting observed, when staff mentioned members' supports, they usually did not specify whether they had seen them, but rather stated the fact that they were involved with the member. The record review showed an average of .60 contacts with a support per month. Interviews	• Continue efforts to engage members' informal support systems as key contributors to the member's recovery team. • The CC should regularly review member records to ensure informal support contacts, including emails and phone calls, are documented. Prompting staff to document contacts reported on in the program meeting may be beneficial. • Brainstorm for creative solutions to increasing attendance to the Friends and Family group. For example, surveying supports as to what they are looking for in a group may lead to greater interest and motivation to attend. Consider whether delivery of the group in community locations that rotate geographically from east to west, for example, may make attendance easier for some supports.

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			and the record review suggest that some contacts with members' supports may not be documented in member records in a timely manner.	
S7	Individualized Substance Abuse Treatment	1 – 5 4	The ACT team has 55 members diagnosed with a COD. The SAS1 and SAS2 split that group roughly in half, with the SAS2 primarily following members in the early stages of recovery, when they do not see their substance use problematic or are largely ambivalent or reluctant to commit to regular participation in substance abuse treatment. It was reported that the SAS1 sees the majority of her co-occurring caseload weekly for an average of 30 minutes, while the SAS2 is able to meet with about a third of her caseload for that same amount of time. Based on encounter reports for both specialists for the month of March, approximately 29 individuals received an average of 43 minutes of weekly substance abuse counseling, for an average across all members with a co-occurring disorder of just less than 24 minutes weekly. Per interview, and as reflected in progress notes found in member records, both SASs appear to follow the co-occurring model. The SAS2 urges other specialists to assist her in the engagement process by asking them to call her directly to schedule individual sessions when they assess new readiness on the part of a member to discuss their substance use and how it might be impacting their lives.	• The SASs and the other specialists should continue present collaborative efforts to engage members identified with a co-occurring disorder in substance abuse treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SASs offer two, one-hour co-occurring groups weekly. The SAS1 facilitates Seeking Safety group, which follows a trauma informed curriculum, *Seeking Safety, A Treatment Manual for PTSD and Substance Abuse*, by Linehan and Beck. Materials provided to the reviewers state the model is evidence based with content areas in cognitive,	• The SASs should continue to collaborate with other specialists to increase attendance to co-occurring groups to include at least 50% of members with a COD. • While a trauma informed approach is

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			behavioral, interpersonal and case management. It was reported the group targets members identified with a co-occurring disorder, but interested members dealing with previous trauma would not be turned away. It was reported that five to eight members usually attend this group. Though the SAS1 offers a Dialectic Behavioral Therapy (DBT) group that the record review showed was attended by some members with a COD, it is open to all members and was not identified as a co-occurring group. The SAS2 began facilitating the Early Recovery group during the month of the review. Before the new SAS2 was hired, the group was covered by the RS who previously served as the SAS on another ACT team. The Early Recovery group follows the RBHA developed *ACT Team Substance Abuse Group Treatment Curriculum*. The SAS2 said that five to six members usually attend the group, but sometimes none. Because attendees may not view their substance use as a problem, often discussion is focused on basic needs, coping skills, identification of resources, maintaining physical health, following a medication regimen and dealing with the behavioral health system. A review of member sign-in sheets for both groups for the month of March confirmed staff report that 16 members with a co-occurring disorders diagnosis attended at least one group. Most of those members attended at least two groups. Three members without a COD attended at least one session of the Seeking Safety group.	desirable, ACT teams should select a substance abuse group curriculum that is more broadly focused on the co-occurring population and moving members through change stages rather than on the subset of members diagnosed with Post Traumatic Stress Disorder (PTSD) for whom this model is designed. Consultation/technical assistance is recommended to ensure that the Seeking Safety group curriculum aligns with evidence-based practice for co-occurring disorders.Co-occurring groups should be exclusive to members with a COD. If provided as a co-occurring group, Seeking Safety should be offered as such.
S9	Co-occurring Disorders (Dual	1 – 5	Of the four staff training logs provided, all had received trainings in COD. The SASs appear to be	• Consultation/technical assistance is recommended to ensure that the ACT team

Item #	Item	Rating	Rating Rationale	Recommendations
	Disorders) Model	4	knowledgeable about the co-occurring model; however, it is unclear whether or not the Seeking Safety curriculum used in one of the substance abuse treatment groups is the best fit for SMI/co-occurring population represented on ACT teams. This is also the case with DBT, which has been found effective with individuals diagnosed with Borderline Personality Disorder, but as yet, has not been more broadly identified as an evidenced based intervention for SMI/COD treatment. Staff said that abstinence is a hope and an ideal that is not immediately realistic for most members, and that talk about abstinence with members who lack stabilizing forces like safe and permanent housing, employment, or a healthy support system may lead to disengagement from the team. Staff interviewed described the ACT team as working collaboratively to increase safety through harm reduction. For example, staff said that while medical marijuana cards are not recommended, staff supported a member in obtaining one to reduce the chances that the member would use marijuana obtained off the street and laced with potentially lethal substances. In addition, although one treatment plan indicated that a member wanted to be "clean and sober", other treatment plans identified reduced substance use a recovery goal. Staff said that they track each member's stage of change in the morning meeting, with the understanding that the stages are nonlinear, and that treatment is designed to align with the change stage. Staff also said that as members seek to reduce use or replace with less lethal means, they help them learn new skills and behaviors to replace addictive behaviors.	is relying primarily on evidenced based practices developed for SMI/co-occurring disorders diagnosed individuals. See Recommendation S8, Co-occurring Disorders Treatment Groups.

Item #	Item	Rating	Rating Rationale	Recommendations
			Staff said they do not refer members to 12-step programs but will support members who would like to use it as a community support. Staff said that they do use detox when the Psychiatrist deems it medically necessary, or when members come in on their own and would like to safely detox, usually from alcohol. Some staff said that members may seek also detoxification from opioids and benzodiazepines, while another staff said that members occasionally wish to detox from cocaine and methamphetamines.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has an identified PSS whose lived experience is that of the parent to adult children with behavioral health disabilities. Per report, the PSS functions as a full member of the team with equal responsibilities. Staff reported that the PSS does a good job of reminding the team of how members and their families can experience the behavioral health system and was likewise described as effective engaging members and their families. In addition, members interviewed said that other team specialists have also self-disclosed their own lived experience of mental illness and substance use and that they find this very helpful in their recovery process. One staff confirmed that some specialists have lived experience of behavioral health issues, as well as homelessness.	• While family members of peers bring a valuable perspective to ACT teams, ideally, the PSS position is filled by a person with the lived experience of recovery in serious mental illness and/or substance use disorders. When considering future staffing needs, the ACT team should ensure that this lived experience is represented on the team.
Total Score:		**4.11**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	5
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	**115/28=4.11**	
Highest Possible Score	**5**	