ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: April 8, 2021

To: Peggy Chase, President and CEO

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AHCCCS Fidelity Reviewers

Method

On March 1 – 2, 2021, Karen Voyer-Caravona and Kerry Bastian completed a review of the Terros 23rd Avenue Health Center Assertive Community Treatment One (ACT I) 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 the Central Region of Arizona.

The ACT I team is operated by Terros Health, a comprehensive healthcare organization, integrating behavioral health and primary medical care. The agency has four ACT teams. Two ACT teams, ACT I and ACT II are located at the 23rd Avenue Health Center in Phoenix, Arizona.

Due to the COVID-19 public health emergency, it was determined that the record portion of the review should be documentation for a period prior to the public health emergency. Reference in this report to the member records reviewed and related documentation are for the period prior to the public health emergency. Due to the public health emergency, the review was conducted remotely, using video or phone contact to interview staff and members. Federal, State, and local government guidance regarding contact with others outside individuals' homes has varied per the positivity rates. Some agencies impose their own guidance which may be more restrictive relating to contact with others.

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

During the fidelity review, reviewers participated in the following:

- Telephonic attendance to a daily ACT team meeting on Monday, March 1, 2021;
- Individual interview with the Team Leader/Clinical Coordinator (CC);
- Individual interviews with the Substance Abuse Counselor (SAC), Housing Specialist (HS), and ACT Specialist (AS);
- Individual phone interviews with five members participating in ACT services with the team;
- Charts were reviewed for ten members using the agency's electronic medical records system; and

- Review of agency documents including: member roster and co-occurring roster; *Meet Your Team* flier; resumes and training records for the Substance Abuse Specialist (SAS), SAC, and vocational staff; calendars for the SAS and the SAC; co-occurring group sign-in sheets; substance use treatment resources; ACT admissions criteria and outreach guidelines; and CC encounter data.

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 5point 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:

- Psychiatric Services: The ACT team is staffed with a full-time Psychiatrist and two full-time Nurses with no responsibilities outside ACT. . The Psychiatrist and Nurses are described as accessible to both members and staff and all were reported to visit clients in their home.
- Responsibility for crisis services: The ACT team is responsible for 24-hour crisis services, with an on-call staff, a backup on-call, and the CC as a final layer of response. The ACT team has continued to respond on-site throughout the public health emergency; members interviewed know how to access the on-call and other ACT staff when in crisis and some reported using the service in the last 12 months.
- Time-unlimited services: ACT services are time unlimited, and members are not pressured to graduate. Although members are considered for graduation when they appear to be functioning well with little assistance from the ACT team, staff support members to consider stepping down to a lower level of care at their own pace, recognizing the role of the ACT team in the member's stability in the community.
- No drop-out policy: The ACT team rarely closes cases due to lack of contact or service refusal but instead seeks to work with members to address needs and service preferences, including assisting members in setting up service elsewhere when they relocate and readmitting members who were briefly closed due to lack of contact.
- Team meeting: The ACT team meets four days a week as a full team to discuss all members. The Psychiatrist is actively engaged with staff, providing feedback, medication and symptom education, and making recommendations to specialists. The CC runs the meeting, providing specific assignments and direction regarding staff follow up with members who have missed appointments or are on outreach.

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

- Practicing team leader: Increase the CC's in-person provision of direct member care to 50% of time. Identify opportunities to assist members in managing concerns about public health guidance and making choices regarding adaptions that lower risk to health and community spread. The CC's in-person services, which may include mentoring specialists in the field and accompanying the Psychiatrist or Nurse on home visits.
- Continuity of staff: Decrease staff attrition to no more than 20% in 24 months. Engaging the ACT team in the candidate selection and vetting process may improve outcomes in staff retention. The agency should seek to hire candidates who understand and are prepared to commit to the ACT model, with its expectations related to community-based services, delivered at high intensity and frequency.
- Responsibility for psychiatric hospital admissions: Strategize to reduce the number of member self-admissions and admissions facilitated by natural supports without team knowledge. Discuss with members and natural support their reasons for not seeking ACT assistance with situations leading up to inpatient admissions, including if they perceive a benefit from not involving the team. When the team is aware of motivations for not involving the team, they are better prepared to negotiate solutions less likely to result in hospitalization while maintaining safety for the member and others in the least restrictive environment.
- Frequency and intensity of community-based services: To the extent allowed in the public health emergency, identify and resolve barriers to the frequency of in-person contacts and time spent with members in services delivered in the community. Strive for engagements that help members develop skills that speak to their priorities and values. In order to support members in their choices about health risk, ensure access to current and accurate public health guidance and adapt to its practice; support members in accessing and learning to use video-conferencing platforms so that members remain connected to the team when concerns about health risk would otherwise leave them socially isolated.
- Informal support system: Increase and properly document all contacts with informal or natural supports, including texts, emails, and phone calls. Leverage the role of the Peer Support Specialist to help members and their supports find agreement on what support looks like in their recovery. Consider consultation and technical assistance in engaging and negotiating with natural supports to be valued participants in the member's recovery team.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of review 11 staff, excluding the ACT Psychiatrist, provided services to 100 members for a member/staff ratio of slightly over 9:1.	
H2	Team Approach	1 – 5 4	Most members interviewed reported seeing at least two different staff, with one of those staff being either a Nurse or the CC during the last seven days. Staff reported that they carry paperwork caseloads only and that specialists make contact with all members. One staff interviewed reported seeing 12 – 15 different members per day, while another reported 30 – 40 members per week. The CC tracks face-to-face contacts in the daily team meetings and asks for volunteers to ensure staff contacts. Staff said that since the public health emergency some members do not want to meet in-person and instead are contacted telephonically. It was reported that drive time between member residences can be challenging for in-person contacts. Per a review of ten randomly selected member records, for a period before the public health emergency, 70% of members saw more than one staff member.	• Monitor staff contact with members so that 90% of members have in-person contact with more than one ACT staff in a two-week period. • Consider solutions to ensuring member contacts with multiple staff by rotating zoned coverage and geo mapping.
H3	Program Meeting	1 – 5 5	Staff reported that the team meets as a group to review all ACT members on Monday, Tuesday, Thursday, and Friday. All staff are expected to attend on days they are assigned to work. The Psychiatrist attends most team meetings, either remotely or in person. Staff said that on Wednesdays the team meets for an all-staff	

			meeting and for team trainings in substance use treatment, but that an additional clinical team meeting may be held if time allows. At the meeting observed, the CC led the meeting, providing direction to specialists as needed regarding conducting outreach or providing member transportation. All staff in attendance reported on contacts and interactions with members, their natural supports, needs, and future appointments. The Psychiatrist participated actively throughout, attending remotely.	
H4	Practicing ACT Leader	1 – 5 3	A review of member records for the period before the public health emergency declaration showed the CC making home visits for medication observation and numerous attempted home visits to follow up with members who had missed appointments or been out of contact with the team. The reviewers were told that that before the public health emergency, the CC spent 40% of their time providing direct care to members. However, since the public health emergency, it was reported that percentage has dropped to about 25% - 35% of time. The reviewers were told that many members are reluctant to have face-to-face contact with staff due to potential health risks. The reviewers were told that the CC continues to conduct home visits, assists members when they come to the clinic, and goes on crisis calls. Encounter data provided for the CC for January 2021 showed the CC providing 1246 minutes, or 13% of service time, in face-to-face member care. Some services to members were delivered via telehealth, however, the fidelity	• Increase the CC's time spent delivering in-person services to at least 50%. This should include meeting with members in the community, allowing for opportunities to train and mentor other staff in appropriate clinical interventions that follow the ACT model. • The CC and all direct service staff should regularly identify opportunities to assist members in managing concerns about public health guidance and making choices regarding adaptions that lower risk to health and community spread.

			protocol does not count those minutes toward provision of direct member care.	
H5	Continuity of Staffing	1 – 5 2	For the 24 months preceding the review, 19 staff left 13 positions, for an attrition rate of 73%. Some positions turned over multiple times. The position with the highest turnover was that of the nurse with five permanent staff leaving the position. In addition to those five, three agency nurses providing coverage between September through December 2020 left the team. The position with the second highest rate of attrition was the Peer Support Specialist (PSS), with three staff leaving that role during the 24 the most recent 14-month period. Staff said that among the factors contributing to turnover in the Nurse and PSS positions may have been a relative lack of experience in both the roles and in the high-intensity ACT model, which requires flexibility, good time management skills, and the ability to exercise appropriate self-direction. Staff said more vetting of experience with the demands of both roles, along with direct input from existing team specialists, may result in improved retention. One staff reported team input on recent hiring for the nurse positions appears to have resulted in better fit for the demands of ACT.	• Screen and orient prospective staff to assess their preparedness to deliver ACT level services. • Examine staff motives for resignation and identify solutions to improve retention. Optimally, ACT teams experience no more than 20% attrition during a 24-month period.
H6	Staff Capacity	1 – 5 4	Data provided to the reviewers showed 14 total vacancies over 12 months. For 13 total positions, the staff capacity rate was calculated at 91%. At the time of the review only one position was vacant, that of the Rehabilitation Specialist. Staff reported a Rehabilitation Specialist (RS) has been hired to start the week following the review.	• Fill vacant positions with qualified staff as soon as possible to achieve staffing capacity of 95% or more.
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a full-time Psychiatrist for 100 members and has no outside responsibilities or caseload. The Psychiatrist is described as easily	

			accessible, available for walk-in appointments, and for telehealth check-ins facilitated in the field by specialists with members who have missed appointments. The Psychiatrist works a four, ten-hour weekday schedule and provides both telehealth and in-person service. Staff reported that the Psychiatrist makes home visits, although this has become less frequent due to the public health emergency. Members interviewed reported being satisfied with services provided by the Psychiatrist.	
H8	Nurse on Team	1 – 5 5	The ACT team has two full-time Nurses who are fully dedicated to the ACT team, with no outside responsibilities or caseload. Staff said that the Nurses are accessible by phone, email and text. The Nurses work four, ten-hour days and attend all team meetings on the days they are scheduled to work. One nurse is scheduled for Saturday, and both are available to specialists after hours or on weekends for consultation. Staff interviewed said that the Nurses visit members in the community for such tasks as medication delivery, medication observation and education, and injection administration.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has two staff providing substance use treatment to 71 members with co-occurring disorders, the Substance Abuse Counselor (SAC) and the Substance Abuse Specialist (SAS). Both the SAC and the SAS have several years of experience providing substance use treatment to adults with serious mental illness. The SAC earned a Master of Human Services and Mental Health Counseling and is a Licensed Associate Counselor (LAC), with an application pending for Licensed Professional Counselor. The SAC provides weekly training to other team specialists in the co-occurring	• The agency should ensure that staff responsible for providing substance use treatment receive and be provided ongoing education and training in the co-occurring/dual disorders treatment model. Maintaining current knowledge of the co-occurring treatment model will support existing and future staff in the role and their ability to cross-train the team.

			treatment model. The SAS earned a Master of Science in Addictions Counseling and is a Licensed Associate Substance Abuse Counselor. The agency provided training records for both staff showing evidence of ongoing trainings in substance use treatment, stages of change, Cognitive Behavioral Therapy for substance use disorders, and mindfulness practice for people in recovery.	
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has one vocational staff, an Employment Specialist (ES), who at the time of the review had been in the role for slightly over 12 months. It was reported that the ES assists members in finding and retaining competitive employment, including resume development, interviewing skills, employment expectations, and job coaching. The ES came to the position with a year of experience assisting ACT members with employment and education goals. A review of training transcripts provided to the reviewers showed a single training in Motivational Interviewing and several trainings in co-occurring disorders, including stages of change. At the time of the review, the recently hired RS had not yet started with the team.	• The agency should ensure that all vocational staff receive ongoing training in principles of Supported Employment and assisting adults diagnosed with serious mental illness find and retain competitive employment.
H11	Program Size	1 – 5 5	Currently, twelve staff service 100 members. The ACT team has a diversity of specialists to meet nearly all the behavioral health needs of its members.	
O1	Explicit Admission Criteria	1 – 5 5	Staff said that referrals to the ACT team mainly come from the Regional Behavioral Health Authority (RBHA) and internally, either as transfers from supportive teams or other ACT teams. The ACT team follows explicit admission criteria developed by the RBHA. Staff interviewed described the criteria is primarily related to high	

			emergency service utilization, homelessness, and lack of success at lower levels of care. Staff said members admitted to the ACT team benefit from greater contact with staff. Staff interviewed articulated reasons member would join the team, such as high use of emergency services, but could not or seemed reluctant to identify specific psychiatric diagnoses that would benefit from ACT level of care. The CC is primarily responsible for screening potential members, although other staff sometimes conduct screenings. The CC and the Psychiatrist review eligibility together and staff with the rest of the team. The Psychiatrist makes the final determination for admission, although the member, unless court ordered, must agree to the service. The ACT team reports no external pressure to accept members that do not fit the criteria, although they generally are expected to accept ACT transfers if an opening is available.	
O2	Intake Rate	1 – 5 5	The ACT team admitted six members in the last six months. Two members were admitted for both the months of October 2020 and January 2021; one member was admitted for November 2020 and February 2021. The team had a wait list of about ten members at the time of the review.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team has full responsibility for case management, psychiatric services, counseling/ psychotherapy, substance use treatment, and employment services. Documentation for a 30-day period before the public health emergency showed little evidence of substance use treatment, vocation services, or counseling psychotherapy provided or being offered. However, in the morning meeting observed by the	• Assist members to obtain housing in integrated settings and provide necessary housing support to retain tenancy.

			reviewers, no evidence of brokered services was found in any of the review activities. Full credit cannot be given to housing because, based on records reviewed and staff interviews, it appears that over 10% of members live in housing where some level of support services are provided by staff outside the ACT team.	
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour crisis services to members. Specialists rotate on-call duties weekly, and a second staff is also assigned to a backup line. The CC provides a final layer of coverage and is available for consultation. Staff, including the CC, respond on-site when crisis cannot be de-escalated over the phone, although staff said this is rarely necessary. Staff will go on-site in pairs after midnight or when safety considerations warrant. Members are provided *Meet Your Team* fliers with all staff and on-call phone numbers. One staff reported helping members enter the on-call number in their mobile phones. Members interviewed were aware of the on-call crisis service and how to contact. One member reported using the service, was provided support in using coping skills, and described the experience as helpful.	• Engage members to include natural supports as active members of their recovery team. Natural supports should be regularly educated to alert the ACT team as a first responder to crisis situations and provided up-to-date information how to contact the on-call service and ACT staff.
O5	Responsibility for Hospital Admissions	1 – 5 3	Although it was reported that the team strives to be directly involved with all inpatient psychiatric admissions, a review of the last ten admissions, with the assistance of the CC, showed this rate to be 50%. Staff reported three self-admissions, two by the same member with a history of refusing team engagement efforts. The other went to the emergency room and was then transferred to the psychiatric unit. A fourth admission involved a member initially taken to the emergency room by	• It is recommended that the team increase member outreach and engagement. Higher frequency of contact and intensity of service may afford the ACT team greater opportunities to assess needs, monitor medication compliance, and provide interventions that reduce psychiatric hospitalizations (See Recommendations for Item S4 and S5, Intensity of Service, Frequency of Contact). Contacts should

			paramedics and the team was not informed by natural support. A fifth member, admitted by a natural support, did not seek out team assistance. Staff said they encourage natural supports to seek team assistance when members are in crisis. In the five cases in which the team was involved, one was voluntary and the other four involved the team filing petitions, amendments, or building a case for persistently and acutely disabled (PAD) status. Despite policies and processes enacted by inpatient facilities to follow public heath guidance, staff reported that the team's responsibilities and priorities have not been altered by the public health emergency. Staff said they continue to transport members and support them through admissions to the extent allowed by inpatient facilities, such as providing medication lists and psychiatric notes, contacting inpatient social workers and nurses, and exchanging information to set up doctor-to-doctor communication. Staff said that many facilities do not allow staff to wait inside the emergency room waiting area and instead require them to wait outside in their cars with the member until inpatient staff calls for the member to be seen. When called, members are then escorted inside for screening and assessment; usually ACT staff are not allowed to accompany the member. ACT staff are not allowed on the unit after admission so follow up visits are conducted over the phone. One staff interviewed said that since the public health emergency restrictions, members are getting admitted more quickly for assessment.	include education on how to access the ACT team and its on-call services when in distress over increased symptoms or in crisis. • Seek to build trust and collaboration with natural supports regarding how to best intervene when members are approaching or in crisis. Peer support in this area should be maximized so that natural supports feel heard and valued as members of the recovery team. Consultation and technical assistance in building alliances with family and other natural supports may be helpful.

O6	Responsibility for Hospital Discharge Planning	1 – 5 4	A review with the CC of the last ten inpatient psychiatric discharges showed that the ACT team was directly involved in 90%. Since the public health emergency most discharge staffings occur telephonically where the date of the discharge and where the member will be going are decided. In most cases, a member of the ACT staff will pick up the member, collecting discharge paperwork, and transport the member to wherever they will be living. In some cases, the inpatient and ACT team will coordinate with a family member to transport the member to where they will be staying and ACT staff will follow up with ensuring the members have necessary medications, a follow up appointment with the ACT psychiatrist within 72 hours of discharge, and schedule appointments with an ACT Nurse and the PCP within ten days. In cases where a member typically loses contact with the team or misses appointments staff will attempt to schedule the member to see the ACT Psychiatrist for follow up assessment the same day as the discharge. For members receiving injections who are difficult to locate, the team will try to coordinate with inpatient staff to administer necessary injections before discharge. Staff said they continue to provide face-to-face contact for at least five days follow discharge to ensure stability and avoid readmission. Staff reported one discharge without team involvement in which the member left the hospital with a natural support against medical advice.	• Coordinate with inpatient staff, members, and their supports (both natural and formal supports) to reinforce the benefits of including the ACT team in hospital discharges in order to meet or exceed direct involvement in 95% or more of inpatient psychiatric discharges.
O7	Time-unlimited Services	1 – 5 5	Staff reported no graduations for the last 12 months and plan to graduate only one or two members in the next. Staff reported measuring	

			readiness for graduation by stability of housing, employment or other meaningful activities, natural support, adherence to medications, keeping appointments, and ability to maintain in the community without use of emergency services for a year or more. Staff described supporting members' expressed readiness to leave the team; staff said that some members are enthusiastic about an immediate stepdown, while others worry about their ability to maintain stability without the team and are supported through a gradual reduction in services. In the team meeting observed by the reviewers, the staff discussed a particular member's perspective on graduation readiness, recognized the member's anxiety, and showed flexibility to proceed at the member's pace.	
S1	Community-based Services	1 – 5 3	Per a review of ten randomly selected member records the ACT team provided community-based services 56% of the time (the record review was for a period prior to the public health emergency). One record showed no contacts in the community and one showed all contacts were in the community. Staff said that the public health emergency has had little effect on their willingness to deliver community-based services; staff interviewed expressed commitment to meeting the needs of members in the community. Staff described following public health guidance to deliver community-based services, including masks, social distancing, and conducting services outside and/or in well ventilated areas. Staff said they are provided personal protective equipment from the agency. Staff try to conform to the comfort level of members, many of whom have concerns about their risk of infection or are	• The ACT team should provide 80% of total in-person contacts in the community, where challenges and learning are the most likely to occur. • As public health guidance allows, assist members to explore and access resources, services, and activities in their community. These in-person contacts should promote skill building in areas such as interpersonal communication, problem-solving, budgeting, and navigating public transportation.

			medically compromised. It was reported that many members rarely or never visit the clinic or accept home visits due to concerns about the public health emergency.	
S2	No Drop-out Policy	1 – 5 5	Staff reported closing two cases during the last 12 months. Of those, one case involved a member relocating out of state, and the team coordinated to ensure continued services in the new location. Another case was closed due to lack of contact but reopened a few months later when the member turned up and accepted services. Staff said that when members refuse services the team attempts to identify reason for refusal, make adjustments to accommodate and, if necessary, transfer to another team or a level of care that the member will accept. The team transferred one member to a supportive team after repeated refusals to engage with the ACT team. Staff reported that when cases are closed it is usually due to death of the member. In the last year, the team reported that five members passed away due to a variety of circumstances. All had been in regular contact with the team and/or had supports in contact with the team.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Per interview, at the time of the review staff said that approximately three members were on outreach. Staff use an eight-week outreach strategy checklist to re-engage out of contact members. At least four outreaches are required weekly, which the CC assigns to staff with specific outreach tasks each day and documents in the calendar during the team meeting to ensure accountability for completion. Staff said that the strategy requires multiple street outreach efforts each week, contact with formal supports and	• Ensure timely follow up with members who missed appointments, especially those scheduled with the Psychiatrist and the Nurses to support proper medication monitoring and management. All attempts to follow up after missed appointments and outreach activities should be documented. • The team should develop a strategy to ensure complete and timely documentation of efforts to locate members who have missed appointments

			other service providers, letters and phone calls to the member and natural supports. In the team meeting observed by the reviewers, the CC guided staff to use a variety of outreach mechanisms; multiple staff were assigned to outreach any one member. The records reviewed, from a period slightly over 12 months ago, did not reflect consistent adherence to the engagement strategy outlined. One record reviewed showed multiple staff, including the CC, making numerous visits to a member's home after a missed injection. Other records showed evidence of specialists following up with members after missed appointments by phone and going to the members home or locations where they are likely to be found. However, two records showed gaps in outreach and contact with members for up to 14 days; at least part of that time a member was in an inpatient psychiatric setting, but it was unclear if this was with or without staff knowledge.	or are on formal outreach, possibly at the time that they are reported upon in the daily team meeting.
S4	Intensity of Services	1 – 5 2	The records sampled showed an average service intensity of 26.88 minutes of weekly in-person contact for a 30-day period before the public health emergency. The average weekly low was 7.75 minutes, while the average high was 260.50 minutes. Staff interviewed expressed awareness of the potential impacts of the public health emergency and associated restrictions on member well-being. It was reported that since the public health emergency, some members are reluctant to come to clinic or have staff in their homes. Some members are contacted by phone. The reviewers	• While following public health guidance, 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 contact and some less week to week based on their individual needs. • While maintaining focus on basic needs and safety are essential activities of ACT specialists, staff should also attempt to engage members in services and offer resources and opportunities to speak to their unique recovery visions. Continually assess for needs and preferences,

			were told that ten members were approved for tablets but frequently need assistance getting logged on.	particularly with members who repeatedly decline services and engagement, and update the service plan to reflect those expressed needs. Ongoing training in and supervision in the use of Motivational Interviewing may increase staff effectiveness with members reluctant to accept engagement and resources offered. Deliver community-based contacts that are individualized and geared toward building skills that help the member achieve goals toward his or her unique recovery vision.
S5	Frequency of Contact	1 – 5 2	The records sampled showed an average frequency of 1.5 in-person contacts per week for the 30-day period under review. The average ranged from a low of .5 contacts per week and to a high of 15 contacts. Member employment appeared to be a barrier to contact in two records reviewed. Two other records examined showed one member who went ten days without any type of documented contact with the team; another record showed that a member went without any type of contact for at least 14 days from the start of the review period. In both cases no contact efforts on the part of the team were documented. Other records showed repeated missed appointments and failed attempts to make contact with members through home visits.	• While following public health guidance, ACT teams should provide an *average* of two hours or more of in-person services per week. This is based on all members across the team; some may need more contact and some less week to week based on their individual needs. • Ensure that all efforts to make contact with members are documented in the member record. • Though members who are employed often would prefer not to disclose their disability to employers and co-workers, discreet observation of members at their places of employment (with the member's permission and when the work environment allows) can be an appropriate means of monitoring functioning and integration needs and assess skills necessary to maintain employment and thrive in the workplace. Discreet observation is function of job coaching that all ACT specialists can be cross trained to provide. Vocational staff and other

				specialists can also arrange to meet members while on scheduled breaks for coffee or lunch for check ins in community settings that offer unique opportunities to monitor, assess, and engage in discussions about next recovery steps.
S6	Work with Support System	1 – 5 2	Per staff report, 50% of ACT members have a natural support network. Each specialist is expected to make weekly contact with natural supports of members on their caseloads. The reviewers heard several reports of contact or intended contact with natural supports in the team meeting observed. Some members interviewed reported having natural support systems and that staff have periodic contact with them. One member reported that staff have helped them locate natural supports with whom they have been disengaged. Other members interviewed reported either having no living relatives or did not have family with whom they wanted contact or involvement in their treatment. The record review showed .70 documented contacts with members for the period reviewed. Some showed multiple emails to natural supports with no evidence of a reply or response.	• Ensure contacts with members' natural supports are clearly documented in member records. Contacts can include email, text, video conference, letter, and phone calls. Vet method of contact preferences with natural supports to encourage follow up response. • Regularly explore with members the benefits of, and any reservations they have about, including natural supports as members of their recovery team. • Help members in growing their natural support network. Natural supports need not be family but can also be found in neighbors, faith-based community, peer run programs, volunteer opportunities, educational settings, and at work settings. Natural supports are a key ingredient to community integration and can be valuable participants in a member's recovery team.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Records reviewed, for a 30-day period before the public health emergency, showed little evidence of individual substance abuse treatment either offered or provided. Fifty percent of records sampled were of members with a co-occurring diagnosis. Some progress notes did appear to reflect engagements appropriately geared toward members in the pre-contemplative change stage but lacked evidenced action steps or plans to move members to next stage. Most progress notes	• Provide education and training to ensure the team is following an evidence-based practice model for co-occurring disorders treatment. • Engage members with a substance use disorder to participate regularly in scheduled individual substance use treatment on the ACT team. Across all members with the co-occurring disorders diagnosis, provide an average of 24

			were oriented toward housing, basic needs, or physical health concerns. One treatment plan identified a plan to refer the member to intensive outpatient substance use treatment but did not identify any services to be provided by the team. Another treatment plan did not list any specific substance use goals or objectives. Staff said the public health emergency has been challenging for substance use engagement but that the team continues to offer services in person or over the phone. Staff do incorporate education on reducing spread of the COVID-19 virus into individual counseling sessions as part of their overall harm reduction strategy for substance use. Per interviews, 47 of the 100-member team were identified with a co-occurring disorder. Staff said that approximately 25% - 30% of those received regularly scheduled individual substance use treatment. Calendars for both the SAS and the SAC provided to the reviewers for the most recent month before the review showed 22 members with a co-occurring disorder received individual substance use treatment. Most were scheduled weekly, but staff said that members may or may not keep those appointments. Per staff report, sessions last between 15 and 60 minutes. Members who prefer not to schedule are worked in. Based on available data provided the reviewers, it was estimated that members with a co-occurring disorder receive an average of 14 minutes of individual substance use counseling a week.	minutes or more of formal structured individual substance use treatment weekly. Documentation of those sessions should clearly reflect a stage-wise approach.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SAC and the SAS each facilitate a co-occurring disorders treatment group weekly, held on Tuesdays and Thursdays. The groups are held in-	• Ensure that co-occurring treatment groups reflect an evidence-based approach

			person at the clinic. The groups are not organized around specific change stages but open to all members with a COD; staff explained that members at varying change stages encourage and motivate each other. Per staff report groups are also open to individuals whose co-occurring disorder refers to nicotine. Staff reported that the SAC and the SAS confer and coordinate content weekly. Staff reported drawing from resources found on the SAMHSA website such *Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders* and Integrated Dual Disorders Treatment. Staff also reported using material from the *Substance Use/Brain Injury Project (SUBI) Client Workbook*. The reviewers were told that public health guidance limits the number of members who can attend groups at one time. At the time of the review, five to seven members attend each group and that 15 – 20 members with a co-occurring disorder attend at least one group monthly. Although sign in sheets for the month of February 2021 were requested, only the first two weeks were provided. Data provided showed that 10 members identified with a COD (21%) attended at least one group in the two-week period. Not included in the calculation were three members who were not identified on the co-occurring roster or whose substance use was nicotine or caffeine. Most of those attending were identified as in the Pre-contemplative and Action stages of change.	appropriately suited for the population served. • Optimally, 50% or more of members with a COD attend at last one COD group each month. All ACT staff should engage members with a co-occurring diagnosis to participate in treatment groups based on their stage of treatment with content reflecting stage-wise treatment approaches. Consider offering one group structured for members in earlier stages and at least one is structed to meet the needs of members in later stages of recovery.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The ACT team appears to be primarily based in the co-occurring model. Staff interviewed appeared to be familiar with stages of change and some familiarity in stage-wise treatment approach. It	• Ensure that all SASs and other specialists are provided training and education on the co-occurring model including the *stage-wise treatment approach (i.e., engagement,*

			was reported that the SAC conducts weekly training for the team in the co-occurring model using SAMHSA materials; the reviewers were provided an electronic copy of copy of *Building Your Program: Integrated Treatment for Co-Occurring Disorders*. Although this was not reflected consistently in either documentation or service plans sampled by the reviewers, staff described a focus on and provided copies of resources using cognitive behavioral techniques, safe coping skills, grounding strategies, wellness and self-care, and harnessing of internal resources and natural supports. Staff discussed at length harm reduction strategies such as reduced consumption and use via less lethal means such as switching from intravenous intake to smoking substances. Staff interviews suggested openness to medication assisted treatment (MAT) but noted often members are hesitant to sign releases to allow ACT team coordination of care with methadone clinics. Staff said that 12-step practices are not a part of substance use treatment on the ACT team but accept that some members seek out such community programs as a supplement to their recovery. Staff reported that detox referrals are at the discretion of the Psychiatrist or Nurse based on medical necessity. It is unclear how heavily the team draws on substance use treatment models that are not evidence-based for co-occurring disorders. The curriculum for stimulant use disorder and substance use for people with brain injury may have relevant content but they are not evidence-based practices for co-occurring disorders treatment.	*persuasion, late persuasion, active treatment, relapse prevention)*. Standardizing treatment around an evidence-based practice for co-occurring disorders treatment such as Integrated Dual Disorders Treatment (IDDT) supports consistent interventions are implemented by staff across the team. • Technical assistance in integrated treatment for co-occurring disorders, including live training for all ACT staff may support consistent adoption of the co-occurring treatment approach.

S10	Role of Consumers on Treatment Team	1 – 5 5	It was reported that the ACT team has a Peer Support Specialist with the lived experience of psychiatric recovery who discloses to members and advocates for the peer perspective with staff. It was reported that other ACT specialists also have lived experience of psychiatric recovery. One staff interviewed reported a member recently contacted the team to express appreciation for the PSS services. Not all members interviewed, however, were aware that there was a person on the team with lived experience. The PSS is new to the team, which has experienced high turnover in the position. One staff interviewed said the previous staff in the role may not have been properly vetted for the demands of an ACT team. The record review did not show the PSS providing peer support or recovery-oriented interventions that one might expect for the specialty role. Progress notes of home visits conducted by the PSS in the role during the period before the public health emergency, recorded the status of basic needs and clinical priorities such as taking medication and performing activities of daily living (ADL), rather than reflecting their work as a specialist on the team.	• Technical assistance may be beneficial in assisting the agency and the team in conceptualizing and supporting the necessary functions of the Peer Supportive Specialist role and the value of the peer perspective in recovery-oriented services. Members should be educated as to the presence and role of the PSS on the ACT team. On some teams, peers inhabit multiple ACT team roles, including SAS, RS and CC and use self-disclosure when appropriate to inspire hope that recovery is possible.
Total Score:		3.96		

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	3
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	3
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	3
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	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
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	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	111/28 = 3.96	
Highest Possible Score	**5**	