ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 30, 2015

To: Kelly Harshberger

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ADHS Fidelity Reviewers

Method

On Monday and Tuesday, November 2-3, 2015, Georgia Harris and Karen Voyer-Caravona completed a review of the Chicanos Por La Causa – Centro Esperanza Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

The Centro Esperanza ACT team was previously reviewed in November 2015 when the clinic was under the ownership of the People of Color Network (PCN). Chicanos Por La Causa (CPLC) acquired the Centro Esperanza clinic in September 2015 after PCN ceased operation. Founded in 1969 by a group of community activists and students of Mexican descent for the purposes of advocating for the needs of the people and neighborhoods of South Central Phoenix, Arizona, CPLC is the largest community development corporation in the state. It provides a range of programs in housing, early childhood education, workforce and economic development and health and human services to urban and rural communities in Arizona, New Mexico and Nevada. Behavioral health services have traditionally focused on children, families, older adults and individuals who abuse substances. According to the agency website, CPLC serves over two hundred thousand low-income people yearly and offers programs and services to anyone in need regardless of "ethnicity, gender, age or creed."

The individuals served through the agency are referred to as *members* or *clients*, 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 the Clinical Coordinator/Team Leader (CC);
- Group interview with two Substance Abuse Specialists (SAS);
- Group interview with Independent Living Specialist (ILS) and the Housing Specialist (HS);
- Group interview with four members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Review of the Clinical Coordinator's member encounter report, the ACT Outpatient Team Meeting Notes for November 2, 2015, and the

Mercy Maricopa ACT Admission Screening and *Medical ACT Admission Screening*.

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:

- Two Substance Abuse Specialists: The Centro Esperanza ACT team benefits from two Substance Abuse Specialists (SAS) with significant experience in substance abuse treatment and behavioral health services.
- Assertive engagement mechanisms: The reviewers found evidence in several member records that staff use assertive engagement strategies, including persistent street outreach, collaboration with other social service agencies, and text messaging to re-engage with members who are missing or may be out of contact with the team.
- Role of consumers on the treatment team: The Peer Support Specialist (PSS) is described and was observed by the reviewers to be a full member of the team with responsibilities equal to other program specialists. Additionally, the two SASs self-identify as people with lived experience in recovery and use their own stories of recovery to build trusting therapeutic relationships and promote engagement with members who are dually diagnosed or abusing substances.

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

- Continuity of staff: The agency and the ACT team should stabilize staff turnover so that it does not rise above 20% over two years. For the review period, staff turnover occurred at a rate of 77.3% over two years with 17 ACT staff members either resigning for positions elsewhere or leaving as a result of administrative termination. High staff turnover has potential negative effects on employee morale, the potential for therapeutic bonds between staff and members necessary to support engagement and recovery, staff training and education, and fidelity in multiple ACT protocols such as responsibility for all treatment services, intensity of services and frequency of contact.
- Intensity and frequency of services: The ACT team needs to increase the intensity and frequency of services, or the documentation thereof. The ACT team, agency and RBHA should work collaboratively to identify barriers and solutions that result in purposeful, person-centered contacts to address the members' needs and identified recovery goals. Ideally, members have contact with multiple staff members during the week, and those contacts take place primarily in the community where challenges and stressors most naturally occur and where learning of new skills and behaviors is best achieved. It was not clear to the reviewers if all documentation of staff face-to-face contact with members had been entered into the electronic record keeping system.
- Co-occurring disorders: The entire ACT team would benefit from structured, thorough training and education in the co-occurring disorder treatment model. Training should be on-going and support experiential opportunities such as peer mentoring and live

supervision to enhance knowledge and competencies. The SASs should be empowered to cross-train the rest of the ACT team so that all staff are prepared to recognize and respond immediately to the needs of members expressing concern about or presenting with symptoms of substance abuse.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The Centro Esperanza ACT team consists of 94 members and eight staff, excluding the team Psychiatrist, at the time of the review. Those eight staff consist of the CC, HS, ILS, two SASs, a Rehabilitation Specialist (RS), Peer Support Specialist (PSS) and the Nurse. The team had two vacancies during this period, the Employment Specialist and an ACT Specialist. The member/staff ratio was 11.75:1. Ideally, the member/staff ratio should be 10:1.	• The clinic and the agency should fill the two open staff positions with well qualified staff as soon as possible in order to align the member/staff ratio with the evidenced-based model of ACT.
H2	Team Approach	1 – 5 2	Staff maintain individual "paperwork" caseloads. Based on staff interviews, it did not appear that the team had a consistent or reliable plan or schedule for ensuring regular face-to-face, community based contacts with members. Members interviewed do not appear to know all the ACT staff or be familiar with their areas of specialization. Some members interviewed said they had not had any face-to-face contact with staff during the last week, while others reported seeing two and three staff respectively. Per a review of ten randomly selected member records, 30% of members had face-to-face contact with more than one staff member in the two week period under review. High fidelity in this area requires a rate of 90% or more.	• The team should develop and implement a solution to increase member contacts with a variety of staff each week, so that members know all the staff on the team and are better able to engage with specialty staff to work on their individual recovery goals. • The CC should research and consider incorporating scheduling procedures for home visits successfully implemented by ACT teams that have scored well on this item. Contacts with various staff, both functioning in their area of specialization and crossed trained, should emphasize community-based contact as opposed to those requiring the member to come to the office since outcomes for new skills and behaviors are higher when learning occurs in vivo.
H3	Program Meeting	1 – 5 5	The ACT team meets Monday through Friday every week from 9:30 – 11 a.m. The ACT team additionally meets on Tuesdays from 2 – 4 p.m. for	

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			staffings. At the team meeting observed by the reviewers, staff discussed all members of the team. The meeting was led by the CC and the team Psychiatrist. All staff were provided a daily Morning Meeting Notes packet with a complete roster of all members and details about diagnosis; Title 19 status; housing status; appointment history with the Psychiatrist, Nurse and staff; as well as notes on support system, medical issues, and individual needs such as employment, counseling or referrals.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated she spent 30 – 40% of her time in direct member services. The CC said that she conducts home visits with one staff member each week and makes contact with members in the lobby, checking in with them on the medications, the living situation, and areas in which they need assistance. Although the CC provided the reviewers with her encounter log, it did not adequately capture real time spent with members to be useful in scoring. A review of ten randomly selected member records, however, revealed only one progress note for five minutes of contact with a member at the clinic. It was not clear to the reviewers how consistently documentation of face-to-face contacts is being entered into member records.	• At least 50% of the ACT CC's time should be spent in face-to-face member services. • The CC should consistently document face-to-face contacts with members in the agency's documentation system. • The CC and the agency should review CC administration tasks to determine if any can be transitioned to other staff at the clinic, such as the Program Assistant, to allow the CC more time to provide direct member service, model meaningful interventions, provide community-based mentoring to staff, and support the team specialists.
H5	Continuity of Staffing	1 – 5 2	The Centro Esperanza ACT team has undergone significant transitions and changes that may have contributed to the high staff turnover rate of 77.3% in two years. That rate reflects the resignation or termination of 17 staff (excluding the Program Assistance) for 11 ACT staff positions. Those changes include administrative terminations, staff transfers, and the transition of	• To improve fidelity in this area, ACT staff turnover should be no more than 20% in two years. High staff turnover threatens therapeutic relationship between staff and members, repeatedly found to be the most critical factor in member satisfaction and successful clinical outcomes. High staff turnover also impairs staff cohesion and

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			the clinic to a different provider organization. Significant to this is the team has had three Psychiatrists in the last year. The ACT team has also had two CCs in the last two years. Additionally, in the last two years, the positions of Housing Specialist, Employment Specialist and Substance Abuse Specialist have turned over multiple times. Member interviews suggest that turnover may play a role in low satisfaction among some members with the level of communication and contact with staff. Lack of training in areas of specialization, as identified by some staff, may also play a role in high staff turnover.	creates organization inefficiencies in terms of lost time and training. If not already in place, the provider should consider using staff exit interviews to determine factors contributing to high staff turnover. Staff satisfaction surveys should also be administered to gather feedback on factors that would (or currently) contribute to staff retention. • The CC and CPLC should continue to give priority consideration to job candidates with education and professional experience in behavioral health and areas of specialization. • Efforts should be made by the agency to provide staff training and support in areas of specialization to enhance competency, skills and confidence in specialty roles.
H6	Staff Capacity	1 – 5 3	The ACT team operated at a staff capacity of 66.7% in the last 12 months. Two positions are currently vacant, the ACT Specialist and the Employment Specialist. The ES position has been vacant for almost a year. The previous managing agency elected to eliminate the position of Transportation Specialist, and replace with a second Nurse position.	• The agency should continue to assess barriers to staff retention and filling specific positions. • See recommendation for H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 4	The ACT team has had three Psychiatrists in the last 12 months. The most senior of the three left the team in August, and a new Psychiatrist was immediately hired into the position. However, when the clinic transitioned ownership from POCN to CPLC, the new Medical Director decided to assume the role of ACT Psychiatrist and the other Psychiatrist was moved to the clinic's supportive team. The current Psychiatrist has been in the	• The ACT team Psychiatrist is a key decision-maker and leader to the ACT team. It is critical that, to the greatest extent possible, members receive psychiatric care from a full-time, permanent team Psychiatrist who can build trust and rapport necessary for successful interventions that support recovery. • ACT teams should have a Psychiatrist

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			position a week and was still being oriented to the team at the time of the review. The reviewers observed the immediate past team Psychiatrist in the morning meeting due to the current team Psychiatrist being scheduled elsewhere. Staff reported that the ACT team Psychiatrist is assigned to the team for 40 hours per week. As Medical Director the team Psychiatrist also supervises the two Psychiatrists and the Nurses who cover the supportive teams and also attends a weekly management meeting for one hour. Due to the fact that the Psychiatrist has only been in the role for one week it was not clear to the reviewers how his dual role as Medical Director would affect his availability to members and ACT specialists.	whose time is 100% dedicated to members. For this reason, the agency should consider ongoing monitoring of psychiatric coverage in order to minimize duties that may distract the Psychiatrist in his role as Medical Director from his responsibilities to ACT members.
H8	Nurse on Team	1 – 5 3	At the time of the review the team had one full-time Nurse. The Nurse helps with medication administration and monitoring, primary care provider (PCP) coordination, psychoeducation and education about physical health, goes out on weekly home visits, engages in street outreach with members who have missed injections, and conducts risk assessments. The Nurse does not have assigned duties outside the team and attends most morning meetings. At the time of the review, the team was in the process of finalizing the hiring of a second team Nurse.	• Continue current plans to hire a second ACT team Nurse.
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has two experienced Substance Abuse Specialists. One SAS has been with the team for nine months, after having spent several years working with members on substance abuse issues while on a supportive team. He is currently	• The CC and agency should consider options for supporting SAS efforts to pursue continued education and training in substance abuse, particularly those

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			pursuing licensure in substance abuse counseling. The other SAS has been on the team for seven months and worked for several years at a methadone clinic doing intakes. In addition, both SAS self-identify as people with lived experience of substance abuse and use their recovery stories to build rapport and motivate members to engage in substance abuse treatment.	opportunities for increasing knowledge and skill in the co-occurring treatment model.
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has a Rehabilitation Specialist who has previous experience working in the school system and in tutoring. She is currently pursuing a Master of Social Work degree and was described by staff as "positive, supportive and encouraging", helping members with resumes, providing job coaching and taking them to job fairs. The team has been without an Employment Specialist for approximately 11 months and is interviewing candidates for the ES position. The CC is seeking ES candidates with previous vocational rehabilitation experience and skills in job coaching, the identification and harnessing of resources and assisting with resume development.	• The ACT team should have two vocational staff with at least one year training/experience each in vocational rehabilitation and support. The agency should support the CC's efforts to hire an ES with relevant training and experience in vocational services. The ES should have the knowledge and skills to directly assist members to find and keep competitive jobs in integrated settings and cross-train other staff in this area as well.
H11	Program Size	1 – 5 4	At the time of the review, the ACT team consisted of nine staff: a CC/Team Leader, the team Psychiatrist, a Nurse, a Peer Support Specialist, a Housing Specialist, Independent Living Specialist, two SASs, and a Rehabilitation Specialist. At the time of the review the team was awaiting the start of a second Nurse, who was newly hired. The position of Transportation Specialist was eliminated to make room for the second Nurse. Two positions, the Employment Specialist and the ACT Specialist, are vacant.	• Ensure that the ACT team has at least ten full-time staff, including the Psychiatrist. • See recommendation H5, Continuity of Staffing.
O1	Explicit Admission	1 – 5	The ACT team receives referrals from hospitals,	

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	Criteria	5	internally from the clinic, and from other providers. The team uses the RBHA ACT Admission Screening Tool; the CC could not recall turning down a referral. When a referral is received, an ACT staff member meets with the prospective member to assess for appropriateness and explain how the team functions and service expectations. The individual must voluntarily agree to join the team. The CC staffs the member with the team Psychiatrist, who makes the final admission determination.	
O2	Intake Rate	1 – 5 5	The CC reported that the ACT team has admitted six members in the last six months, and that no more than two members per month were accepted in the last six months.	
O3	Full Responsibility for Treatment Services	1 – 5 2	The Centro Esperanza ACT team does not appear to have full responsibility for services in several areas, including case management, where a few staff estimated that 30% of members receive some degree of case management services from outside the team. They provide psychiatric services, and no members receive psychiatric care from outside providers. The RS provides employment services to eight – nine members in vocational activities such as resume building, visiting job fairs, online job searches and job coaching, although it is not clear if the focus is on competitive employment in integrated, community-based settings. The lengthy absence of a trained Employment Specialist on the team may contribute to this ambiguity. Approximately four members receive job coaching through outside vocational programs (work adjustment training) such as Odyssey by VR referral.	• The ACT teams should be fully responsible for all services, including case management, all psychiatric services and medication management, housing support, and employment and rehabilitative services. No more than 10% of any type of service should be brokered to outside providers. • The agency, RBHA and the ACT team needs to identify and implement a solution to the problem of very high staff turnover. See recommendations for Item H5, Continuity of staffing. High staff turnover over the last two years may have compromised the team's ability to operate as a cohesive unit with full responsibility for all services or for staff to obtain and benefit from specialty training necessary to function within their areas of specialization. Some staff

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			The HS assists members with housing applications and makes efforts to develop relationships with landlords and property managers. The ILS provides members assistance with numerous in-home needs such independent living skills, grocery shopping, and budgeting, as do other ACT staff. Some members have received assistance with housing searches through outside PSH providers such as Marc Community Resources' Hope Program which does provide peer support workers who assist members with housing searches, budgeting and setting up their apartment. Staff estimated that 25% of members receive housing support from outside providers. The ACT SASs provide one substance abuse treatment group per week, which is attended by two – five members. About six members attend a substance abuse group offered by the co-located provider Valle del Sol that is open to members of all the clinic teams. The SASs do not provide individualized substance abuse counseling psychotherapy; staff explained that they cannot provide this service because they are not currently licensed to do so and instead refer members in need of this service to the co-located provider. Per staff report, other services are at least partially brokered. Approximately 30% of members received counseling or therapy from outside providers. Some staff said the team would benefit from more cross training and describe turnover as contributing to diminished time available for cross-training. "We don't have time to teach each other	identified this as an immediate need for all staff. Staff who receive the targeted training, mentoring and supervision specific to function in their areas of specialization may reduce the ACT team's reliance on brokered service providers, as well as improve fidelity in other areas such as community-based services (S1), intensity of service (S4), and frequency of contact (S5). • The agency and the RBHA should consider soliciting feedback from ACT staff, possibly through consultant facilitated focus groups or surveys, to identify barriers and solutions to the team directly providing the full array of services. It was not clear to the reviewers if all staff interviewed were comfortable talking about their need for additional assistance or support.

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			what we know." Staff also said the team needs more training specific to each area of specialization.	
O4	Responsibility for Crisis Services	1 – 5 4	ACT staff rotate on-call responsibilities on a weekly basis (Wednesday – Wednesday). A detailed plan of responsibilities and backup plans was not provided to the reviewers; however, per interview, ACT staff's role in 24-hour emergency care is to provide members with "the extra support . . . if you have a hard time at night, we provide support with coping skills, with the listening ear and play a big role in making sure needs are met." Crisis line staff contact the ACT team when they are called first about a crisis. The ACT team goes to the scene of the crisis when the Mobile Team is called. It was unclear from both the member and staff interviews if the ACT team was consistently viewed as the first responders in crisis situations by members.	• Ensure that the ACT team is understood by members, informal supports, guardians, PCPs, and crisis/emergency services providers as the primary responder for members in crisis, 24 hours a day/seven days a week. • Provide education and reminders to members regarding the ACT team's role in crisis services and provide them with a printed copy of the on-call and staff phone numbers. Ensure that provided information is updated as changes occur.
O5	Responsibility for Hospital Admissions	1 – 5 4	The ACT team was in involved in seven out of the last nine (77.8%) hospitalizations offered for review. Per interview, members sometimes self-admit or are taken to the hospital by family which may delay notification to the ACT team. Sometimes hospitals do not immediately notify the ACT team. The team seeks to only use hospitalizations as the last resort but will work with members who feel they cannot manage symptoms, as well as coordinate with guardians, family members and hospitals to gain admission. When necessary, the team uses amendments and petitions to hospitalize members when they are in immediate danger to themselves. While the ACT team policy is that hospitalized members are seen every 72 hours, it was not clear from charts reviewed that this was occurring.	• Ensure that all members and their informal supports have the team on-call phone number and staff phone numbers so they know who to contact for support if the need arises. • To the extent possible, obtain releases of information (ROI) for all members and periodically review for updates or changes in contacts. Discuss with members the importance of involving informal supports in treatment who can assist in advocating for their needs. • The agency should work on ways to develop more consistent, accurate documentation of services.

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O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The ACT team was involved in all of the last nine hospital discharges provided for review. In one of the nine cases the ACT team coordinated with the hospital social worker for the member's mother to pick him up, as well as coordinated the member's follow up appointment with the team Psychiatrist.	• It is recommended that ACT staff be at the hospital for discharge even in cases in which the member would prefer to be picked up by family or other informal support.
O7	Time-unlimited Services	1 – 5 4	The ACT team anticipates discharging six members (6.4% of the current roster) in the next 12 months. The ACT staff described the team as transitional, a place to learn to be self-sufficient and gain stability. Staff reported that they feel some members are ready to step down to a supportive team before the member does, and that they respect the member's point of view.	• The ACT model is not designed to be transitional care but rather a long-term, time unlimited service for those with the most significant and chronic symptoms of serious mental illness. In this model it is not expected that more than 5% of members would graduate or step-down annually. Members may be able to reduce their reliance and contact with the team but should still have it immediately available in the event a crisis situation. The ACT team should carefully review intake criteria to ensure all admission to the ACT team fit the criteria.
S1	Community-based Services	1 – 5 3	Most of the members interviewed reported that they see staff primarily in their home. However, a review of ten randomly selected member records found that 58% of staff contacts with members occurred at the clinic. The range of time spent in the community was fairly evenly distributed from 0% - 100%, and was bi-modal with two members receiving 0% community based contacts and two members receiving 25% community-based contacts. Staff report offering several groups at the clinic including a substance abuse group, a men's group, an art group, and a guitar group.	• The ACT team should strive to provide 80% of services in the community, providing real time interventions in real life situations where members experience stressors and challenges. • While it is recommended that the ACT team pursue plans to expand the number of ACT specific substance abuse groups offered, the team should minimize use of unnecessary facility-based interventions, which do not encourage members to rely and use community resources and social supports to meet needs or find solutions. Some group offerings, while beneficial and popular with members, may be more

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			It was not clear to the reviewers if face-to-face member contacts were consistently documented in the member electronic records. Seven records reviewed found three or four recorded face-to-face contacts between members and staff.	appropriately provided by peer run programs. • The agency should work with ACT staff to brainstorm ideas for increasing the implementation of areas of specialization in the community and ensure that those services are consistently and accurately documented in the member record. Supportive housing services, assisting with employment goals, peer support, and skill development activities, for example, can be performed in the community, providing staff the opportunity to model new behaviors, observe learning barriers, and provide in-time feedback. In addition, staff can obtain valuable baseline information, assess needs of the person in their environment, and monitor member progress.
S2	No Drop-out Policy	1 – 5 5	During the period under review, the ACT team had only one member refuse services. The member contacted the ACT team after relocating out-of-state and rejected offers to assist her in securing behavioral health services in her new location. Two members refused services but their cases were kept open and both eventually elected to return to the team. Four members are currently incarcerated but remain open on the team. Staff take a patient approach with members who refuse services; several said that members usually reengage when they have a need of assistance.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The team has an eight week contact strategy. Interviews and evidence found in ten member records showed that ACT staff use assertive engagement mechanisms to maintain contact with	

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			members, such as making contact with family, shelters, and jails, and coordinating with payees. Documentation found in one chart noted a series of text messages between a staff member and a member who appeared to be evading contact with the team. ACT staff also successfully coordinated with a shelter to make face-to-face contact with a member who could not be located for several days.	
S4	Intensity of Services	1 – 5 2	ACT teams operating at high fidelity provide an average of two hours of face-to-face contact for each member per week. According the review of ten randomly selected records, members of the Centro Esperanza ACT team receive an average of 23.13 minutes of face-to-face contact with ACT staff per week.	• The ACT team needs to increase service intensity to members to *an average of two hours per week for each member*. The agency should review services currently referred to outside providers with consideration to whether they would be more appropriately provided within a fully functional ACT team's areas of specialization. If it is found that some activities should be managed by a fully functional ACT team, the agency and ACT staff should identify any barriers to implementation. • See recommendations for Item O3, Full Responsibility for Treatment Services. • Increasing delivery of service in the community may result in an increase in service intensity. See recommendations for Item S1, Community-Based Services. • The agency should work on ways to develop more consistent, accurate documentation of services.
S5	Frequency of Contact	1 – 5 2	The CC estimated that in a two week period, 45% of members see more than one staff member. However, a review of ten member records showed that ACT members received contact with an	• See recommendation for Items O3, Full Responsibility for Treatment Services, S1, Community-Based Services, and S4, Intensity of Services.

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			average of one staff member with a two week period. It was not clear to the reviewers if documentation of member contacts had been completed for the period reviewed, and omissions of face-to-face contact notes may account for the score on this item. Staff interviewed reported that they have contact with between five – six different members per day. Staff said they may see more members if they are facilitating a group. Staff assigned to blue dot calls and walk-ins may also see more members on that day. Some members interviewed said that they had not seen any staff during the last week, while others said they had seen two to three in the same period.	
S6	Work with Support System	1 – 5 2	Twenty staff contacts with supports were counted in the team meeting observed on November 2, 2015. Staff reported that 45% - 50% of 94 members have an informal support network, and the ACT team has contact with 20% - 25% of them about three times a month. Staff said some members do not want staff to have contact with their informal supports. Some members interviewed said that the ACT team regularly spoke with family or other informal supports, while one member said that they team does not "but should". Of ten records reviewed, the team had contact with less than .5 contacts per month. As mentioned previously in this report, incomplete documentation may account for this discrepancy.	• ACT staff should periodically review with members the benefits of allowing contact between staff and informal supports. This discussion could occur at the time of Individual Service Plan (ISP) reviews, changes to the ISP and/or staffings. If members agree to sign an ROI, staff should ensure that informal supports are provided up-to-date contact information and encouraged to follow up with the team with concerns or feedback about member needs. If members decline to sign an ROI, staff should indicate this clearly in the member record, perhaps using a prompt on the ISP or within the electronic record system. • Ensure that contacts with member informal supports are consistently entered into the member record. If not already understood, staff should be educated that they can receive and document concerns reported

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				by informal supports for whom the member has not signed an ROI. • Increasing community-based service delivery may result in increases in contact with informal support network. For example, staff can help a member locate and visit houses of worship, attend an AA meeting with a member, or provide education to a member's employer about psychiatric symptoms or effectively offering critical feedback.
S7	Individualized Substance Abuse Treatment	1 – 5 3	Although the SASs reported that 42 members are diagnosed with a substance abuse disorder, staff said they do not provide formal, individualized substance abuse counseling because the ACT team does not have licensed staff to perform the service. Approximately three members are in formal, individual substance abuse psychotherapy provided by the co-located Valle del Sol clinician. The SASs, however, reported that they meet with 12 – 15 members for 15 – 20 minutes in weekly one-on-one sessions during scheduled home visits. Evidence was found in several member records of SASs providing some individual substance abuse counseling during home and office visits. Members set the pace in these sessions, which are supportive and psychoeducational in nature and focused on triggers, coping skills, family issues and avoiding relapse. Based on the information provided for the 42 members, the SAS provided a weekly average of 5.62 minutes of individualized substance abuse treatment to ACT members with a substance abuse disorder.	• Since the ACT protocol does not require licensure or certification in substance abuse to provide individual substance abuse treatment, the agency should clarify and find solutions to any barriers the team from having primary responsibility for individualized substance abuse treatment. If unlicensed SASs can provide individual substance abuse treatment ensure that staff have the appropriate level of guidance, supervision, and clinical oversight.
S8	Co-occurring Disorder Treatment	1 – 5	The SASs reported that an average of five of the 42 members diagnosed with a co-occurring disorder	• Move forward with plans to implement a second ACT specific substance abuse

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	Groups	2	(11.9%) participate in at least one ACT substance abuse group per month. The group is scheduled every Monday. The record review did not reveal any evidence of members attending the substance abuse group. An additional four members attend a Friday substance abuse group facilitated by the co-located provider that is open to the entire clinic. The SASs are planning to start a second ACT member-only substance abuse group to be held later in each week to help members prepare for managing cravings and risk of relapse over the weekend.	treatment group. Consider using a structured curriculum that emphasizes the principles of the co-occurring disorders treatment model/stage wise approach. • See recommendation for Item S9, Co-Occurring Disorders Model.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Some ACT staff appear to be familiar with the stage-wise treatment approach, and described members who actively attend groups or are being seen in weekly one-on-one sessions fluctuating between all the stages, from pre-contemplation to maintenance. In general, the terms and techniques discussed among other staff members seemed to reflect a more traditional approach to helping members manage their abuse of substances. The SASs embrace harm reduction and describe complete abstinence as highly unlikely for most of the dually diagnosed members they serve but also acceptance of confrontational and punitive approaches in some cases. SASs still view abstinence as the end goal but see stability as more readily attainable and strongly encourage 12-step approaches as "very revealing". Detox is seen as helpful with members abusing opiates, benzodiazepines, and alcohol. Some staff shared that they do not recollect any recent substance abuse trainings, from which staff would greatly benefit. Staff described RBHA training in substance abuse as superficial, and	• The agency and the RBHA should collaborate to ensure that all members of the ACT team receive thorough education and training in the implementation of the co-occurring disorders model. Training opportunities should be repeated, at least annually, and provided at the earliest opportunity for new hires, and include the stage-wise approach and motivational interviewing. Supervision, treatment team meetings and documentation should reflect attention to each member's stage of change, and discourage use of any language and terms that are inconsistent with therapeutic, co-occurring modalities of treatment. Using inconsistent terms could undermine attempts to build team cohesion in implementing the co-occurring model, and ultimately its effectiveness with members. • Explore opportunities for the SASs to provide cross-training to the rest of the ACT team. All ACT specialists should be

Item #	Item	Rating	Rating Rationale	Recommendations
			insufficient to prepare ACT staff to differentiate between behaviors typical for substance intoxication (such as with crack or cocaine) and those seen in individuals with acute SMI symptoms.	prepared to assess and respond to members who express or demonstrate immediate substance abuse concerns or symptoms rather than delaying intervention until the SAS is available.
S10	Role of Consumers on Treatment Team	1 – 5 5	Team has an experienced PSS, who has been with the team for nearly three years. In addition, two SASs self-identify as people with lived experience and use their personal stories of recovery to help support dually diagnosed members through the stages of change and motivate them to work on their own recovery.	
Total Score:		**3.50**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	2
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	4
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	2
4. Responsibility for Crisis Services	1-5	4
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	5
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	3
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.50**	
Highest Possible Score	**5**	