ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 25, 2015

To: Tamera Spradlin, ACT Clinical Coordinator

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ADHS Fidelity Reviewers

Method

On November 2-3, 2015 T.J. Eggsware and Jeni Serrano completed a review of the Southwest Network San Tan Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

Southwest Network provides behavioral health services to youth and adult populations. Southwest Network staff provides services out of seven outpatient clinics, five of which have ACT teams. Per the agency website, services at the clinics can assist members to address substance use issues, if applicable, to connect with family and the community, to pursue education and employment goals, as well as to help with independent living. The program was reviewed previously on January 20-21, 2015.

The individuals served through the agency are referred to as "members" so that term will be used in this report.

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

- Observation of the team morning meeting on November 2, 2015
- Individual interview with Clinical Coordinator (i.e., Team Leader), Substance Abuse Specialist (SAS), Peer Support Specialist (PSS), and Independent Living Skills Specialist (ILS)
- Group interview with four members, and one individual member interview
- Charts were reviewed for ten members using the agency's electronic health records system
- Review of the *ACT Eligibility Screening Tool* developed by the Regional Behavioral Health Authority (RBHA), *Assertive Community Treatment (ACT) Team Substance Abuse Group Workbook* developed by the RBHA*,* the agency *ACT Admission/Transfer/Discharge Desktop Procedure,* and the agency *Closure for Lack of Engagement Desktop Procedure*

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The staff-to-member ratio and team size is within identified fidelity standards.
- The team intake rate ranged from zero to three members over the past six months, within preferred thresholds for new admissions to the team.
- The team reports few drop-outs; they have retained members at a 98% rate.
- The team reports involvement in all hospital admissions, maintaining a high level of contact with members who are hospitalized, coordinating with inpatient staff, and supporting members when they discharge.

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

- The ACT team, the agency, and RBHA should collaborate to discuss barriers to the ACT team maintaining a high level of contact with members; explore opportunities to support staff to increase intensity and frequency of services to members. For example, prior to referring a member to an external provider (e.g., for residential treatment, substance abuse treatment, employment supports), review what the other program will offer that the team is not expected to provide.
- Services should be delivered primarily through the ACT team, in the community. Some activities, such as substance abuse treatment groups, may continue to be offered in the clinic, but to the extent possible, other services should occur in the community. As part of engagement, provide structured and purposeful contact with all members in place of brief clinic check-ins with multiple staff. Involve specialists to engage members based on stated member goals; for example, vocational staff should work with members to support employment goals and staff should not discourage members from seeking employment.
- Ensure SASs are trained, receive supervision, and are empowered to cross-train other team members in order to implement a recognized stage-wise integrated dual diagnosis treatment model to standardize the team approach. Currently, SAS staff does not provide formal individual substance abuse counseling; primarily members are engaged to discuss substance abuse concerns, offered the substance abuse group, or referred to external providers. Per report, the SAS staff is not professionally licensed. The SAMHSA ACT model does not require licensure or specific certification as a requisite for staff to provide substance abuse treatment; training and experience are the focus.
- Continue to engage informal support networks of members; discuss how the team can support them to assist members. It is recommended the team support and encourage members to identify their informal supports (i.e., people not paid to support members, such as family, landlord, neighbor, friend) and then assist them in acquiring the knowledge, resources and skills needed to support members.
- Consider seeking input from members, informal supports, frontline staff, and other ACT teams regarding how services in lower fidelity areas can be improved at the team and system level.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team serves 97 members with ten staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of 10:1.	
H2	Team Approach	1 – 5 (4)	During interviews, staff spoke of primary caseload assignments, and stated they work with all members on the team. Staff reports they offer to visit members if they live in an area where staff are travelling for other duties. Based on ten records reviewed, 80% of members met with more than one staff over a two-week period.	• Ensure the majority of members have contact with more than one staff during a two-week period, and that all services are documented. • If primary caseloads are assigned for specific paperwork-related tasks, ensure the roles of specialty staff are fostered, and they provide cross-training to other staff. Consider orienting members to all current team specialists, their roles, what they can expect from the staff and the team, as well as contact numbers for the specialists.
H3	Program Meeting	1 – 5 (5)	The ACT team meets for morning meeting Monday through Thursday. On Friday the Psychiatrist and one Nurse are off due to working a flexible schedule, but the other team members meet briefly to review issues for the day. The Psychiatrist and Nurses attend daily morning meetings, with the exception of the second Nurse who flexes her schedule and is off on Tuesday. Staff report one Nurse and the Psychiatrist are sometimes late to meetings due to appointments, and one Nurse occasionally leaves early for appointments. The reviewers observed a morning meeting on November 2, 2015 from 10:00-11:20 AM. All members of the team were discussed, but much of the conversation focused on medication services including medication observations, and medication	• Review Psychiatrist and Nurse schedules, and consider adjusting to ensure they can attend full meetings. • Once all staff vacancies are filled, ensure members are supported by the entire team and not primarily through one Case Manager (CM). Some teams elect to review members by area of specialty which emphasizes the specialty positions.

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			doses, with limited discussion for some members (e.g., doing good, doing well, or stable). Though there were some references to Housing Specialist activities, there was limited information regarding other specialist interventions; staff provided updates, but it appeared they primarily reported on their assigned primary caseload or those with whom there was recent contact for medication services (e.g., medication observation, injection or medi-sets).	
H4	Practicing ACT Leader	1 – 5 (3)	Based on available information, it appears the Clinical Coordinator (CC) provides services routinely as backup, with evidence the CC does complete home visits, and makes contact with members at the clinic. The CC is aware she should be spending at least 50% of her time providing direct services to members. She reports direct services she provided, measured in units of encountered services (i.e., billed minutes), which averaged 65% of the CC's time over a two month period. The encountered service estimate was higher than the actual service minutes captured in documentation. In ten member records reviewed, only one direct service contact was documented by the CC over a month period, but the CC was on vacation for 11 days of the month. Another similar timeframe was reviewed to determine CC direct services over a typical period. Over a month timeframe, direct services to members accounted for approximately 11% of the CC's time.	• The agency has implemented tracking mechanisms in an effort to align team monitoring with the fidelity tool. Continue efforts to monitor and track data with regard to this item; connect CCs who may be providing higher levels of direct services with CCs who are struggling to provide direct member services (for ideas and guidance). • Review CC administrative tasks to determine if any of those can be transitioned to other staff at the clinic or agency to allow the CC more time to provide direct member services, to model interventions, and support the team specialists.
H5	Continuity of Staffing	1 – 5 (4)	Over the two year timeframe at least eight staff left the team, resulting in a 31% -38% turnover rate. Though one of those staff left the team and returned, he was gone for more than three months and was included in the calculation, and staff reported multiple Psychiatrists assisted the	• If not in place, the agency should consider conducting exit interviews/surveys to determine what contributes to staff turnover, whether at the agency or system level.

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			team over a period when the team was without an assigned Psychiatrist.	• If not in place, conduct staff satisfaction surveys to determine what is working to retain staff. For example, when asked how the program or services might be improved, staff report specialty specific training and guidance would be beneficial.
H6	Staff Capacity	1 – 5 (3)	The team operated at 78% of staff capacity over the year timeframe, with 35 total vacancies over a 12 month period. Two positions are vacant, the Employment Specialist (ES) and the second SAS, but the team plans to transition the ILS to the role of ES.	• The agency should continue to assess barriers to filling vacant positions • See recommendations for H5.
H7	Psychiatrist on Team	1 – 5 (4)	There is one full-time Psychiatrist assigned directly to the 97 member program. Though the Psychiatrist attends team meetings, provides some community-based services, and is accessible, he does have some duties outside of the team. The Psychiatrist does see members of other clinic teams; staff estimate these activities recently increased to approximately 10 – 25% of the Psychiatrist's time is spent serving members from other teams.	• The agency should explore options for clinic coverage so that the Psychiatrist is able to maintain focus on ACT members, not compromise his contributions to staff training, and allow for increased availability for collaboration and commitment to community-based services. Preferably, ACT teams of this size have a Psychiatrist whose time is 100% dedicated to team members. • Consider establishing ongoing clinic monitoring of Psychiatrist coverage to minimize the additional responsibilities and the number of non-ACT members that are served by the ACT Psychiatrist.
H8	Nurse on Team	1 – 5 (4)	As of July 20, 2015, the team has two full-time Nurses assigned to the team, and the CC reports that with the addition of a second Nurse, they have been going to the community more, including taking members to Primary Care Physician (PCP) appointments, taking members to the emergency room if necessary, coordination with other medical providers, as well as continuing to provide medication services (e.g., injections, medication	• The agency should work to reduce nursing responsibilities outside of the ACT team; train and educate other staff at the clinic regarding the purpose of having two Nurses assigned to the ACT team, which could help minimize requests for nursing activities outside of the ACT team. • Continue efforts to support Nurses as they increase their community-based services to

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			observations) for members on the team. The Nurses have assigned caseloads of ten members each consisting of members with more complex medical issues. Although both Nurses work flex schedules, staff report they are accessible, and attend morning meetings. However, one Nurse is the lead Nurse at the clinic, and staff estimated her responsibilities associated with that position account for approximately 30% of her time, and the second Nurse spends approximately 10% of her time providing services to members from other teams. One staff estimated about 20% of one Nurse's time is spent on duties outside of the ACT team due to another clinic team being without a Nurse and the ACT Nurse providing coverage.	ACT members.
H9	Substance Abuse Specialist on Team	1 – 5 (1)	The team has one unlicensed SAS, who has been in the position since April, 2014. Although the SAS has experience working with individuals with dual diagnosis, it is not clear if he has received ongoing supervision and training in an integrated model of treatment, and any prior applicable experience appears to have been ancillary to other positions he held (e.g., case management activities). When asked about training history, it was reported the SAS received American Society of Addiction Medicine (ASAM) training. However, the SAS is not familiar with a stage-wise approach to treatment, had difficulty identifying the treatment model utilized by the team, but did note the team used a recovery based approach.	• The agency and RHBA should train SAS staff in a stage-wise integrated dual diagnosis treatment model; ensure the SAS staff receive supervision to monitor the treatment of adults with co-occurring challenges. Familiarize ACT staff with a stage-wise approach to treatment and ensure staff identified in the role of Substance Abuse Specialists receive support, monitoring, and education in the role for the population served (i.e., adults diagnosed with a serious mental illness). • Since the agency has multiple ACT teams, consider consolidating clinical supervision of SAS ACT staff under one supervisor so ACT SAS practice in a more consistent manner across teams at the agency.
H10	Vocational Specialist	1 – 5	The team has one vocational service staff, the	• The agency should provide training and

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	on Team	(2)	Rehabilitation Specialist (RS). The Employment Specialist (ES) position is vacant; the current ILS is transitioning into that role, but this had not occurred prior to the review. Staff report the RS attends trainings with other RS staff which are facilitated by the RBHA, in addition to core staff training, but it is not clear if the identified staff have education or sufficient training to successfully fill the role of vocational specialists. Also, it does not appear the team consistently provides individual employment services focused on directly assisting members in job searches and sustained employment in integrated work settings. Based on documentation, staff report, and observation of the morning meeting, program staff discusses employment with members, but do not assist with all phases of the employment search, relying primarily on referrals to external employment support service providers. In some cases, members expressed employment goals but were discouraged by staff from seeking employment.	guidance to staff identified in the role of Vocational Specialists (i.e., ES and RS) so they are able to assist members to find and keep jobs in integrated work settings. The team should identify barriers to directly providing vocational services versus referring to outside providers. • The agency has multiple ACT teams; consider reviewing options to determine if one supervisor with vocational experience can provide training/guidance to staff in vocational roles across all agency ACT teams.
H11	Program Size	1 – 5 (5)	Although the team is not fully staffed due to one SAS position vacancy and one ES position vacancy, the team is of appropriate size with 11 staff (excluding administrative support staff). The team is transitioning the current ILS to the vacant ES position.	
O1	Explicit Admission Criteria	1 – 5 (4)	Per staff report, members are generally referred from other teams at the clinic or other agencies, through the RBHA. Due to the program census, the team does not generally find it necessary to recruit for new referrals. Members are screened for ACT, either by the CC or	• Ensure all ACT staff are empowered to provide input on potential new admissions to the team; the full team should make the final determination. Optimally, the team should be equipped to make the final determination whether members are

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			other team staff, using the *ACT Eligibility Screening Tool* developed by the RBHA. Once the assessment is done the team speaks with the doctor, ACT staff provides input, and the doctor ultimately determines whether a member is admitted to the team. The CC reports the team has experienced some administrative pressure from the RBHA to accept members the team determined to be inappropriate for ACT services.	admitted to the team without administrative pressure.
O2	Intake Rate	1 – 5 (5)	Per report, the peak intake rate in the six months prior to review was three members in the months of July and October, 2015, with one admission each the months of May and August, 2015, and no admissions for June and September, 2015.	
O3	Full Responsibility for Treatment Services	1 – 5 (2)	In addition to case management, the ACT team directly provides psychiatric services and medication management to members. It does not appear the ACT team provides 90% or more of housing, substance abuse treatment, or employment/rehabilitative services directly. The team does not provide counseling services. Though the team provides in-home support to members, 12% of all members reside in settings with non-ACT staff support (e.g., residential treatment). The ACT team offers substance abuse treatment engagement and groups, but refers out for individual and some group treatment. Based on staff report, and morning meeting observation, more than half of members who receive substance abuse treatment are referred to other providers. There was limited evidence in records and morning meeting observation that the team directly supports members seeking employment. In one record it was documented staff assisted a member (as part of a group) to apply for	• The agency, RBHA, and ACT staff should collaborate to develop solutions to reduce the reliance on brokered services; with few exceptions, the team should directly provide employment, substance abuse treatment, and housing support to the majority of members who receive services in those areas. • The agency and RBHA should solicit input from ACT staff to identify barriers to the ACT team directly providing the full array of services. Before referring a member to an external provider, the team should review what that program will offer that the ACT team is not expected to provide. • The agency and RBHA should continue to review training and supervision options to ensure staff designated with a specialty area receives monitoring, support, and supervision specific to their role. Explore opportunities for professional development

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			employment in the community. However, in two other records it was documented that members with employment goals were discouraged from seeking employment in order to focus on other issues the team identified as concerns. The team engages members to develop employment and rehabilitative goals, supports members to explore socialization programs, but refers members out to brokered providers for most employment services. Staff spoke of their primary caseload assignments, and appear to primarily provide services to those members. Though the team reports staff is cross-trained, it appears this cross-training relates primarily to general case management due to the team utilization of outside providers for services (e.g., residential, substance use treatment, counseling, employment supports). Members discuss their primary CM staff, and do not appear to be aware of all positions on the team (e.g., PSS). However, it is difficult to determine if members are served through the entire team because most members interviewed receive frequent contact for medication observations or office-based supports. As a result, those members appear to have more contact with ACT staff than what was documented in a random sample of member records reviewed.	for staff in specialty ACT positions. Staff report additional training and guidance to clarify their roles and responsibilities will be beneficial. The agency has multiple ACT teams; consider centralizing supervision or training responsibilities for ACT specialty positions across ACT teams. • Consider assigning specialty staff as primary contacts for members with goals or challenges that align with the specialty area. For example, a portion of the SAS caseload may be comprised of members in a stage of recovery, a portion of the ES primary caseload may be members with employment goals, allowing for more direct and ongoing assistance.
O4	Responsibility for Crisis Services	1 – 5 (4)	The ACT team CC reports the team provides crisis services coverage, with staff rotating an on-call phone weekly, and the CC providing back-up availability. The team assesses the situation and the team will go out if they cannot support the member over the phone. The CC reports the list of team contact numbers is provided to members at program intake, and most	• Ensure all members are provided with the on-call and other staff contact numbers, not only at team admission but as staff changes occur and periodically through treatment (e.g., when treatment plans are updated). Provide education to members regarding the team's role in crisis services; that is, to provide crisis stabilization services to all members 24 hours a day.

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			members are aware of the number, though members interviewed report they did not receive the on-call information from the team and are not sure who to contact if they experience a crisis after 6:00PM when the office closes.	
O5	Responsibility for Hospital Admissions	1 – 5 (4)	During office hours, members usually meet with staff and the Psychiatrist in an effort to prevent hospitalization. Per report, the Psychiatrist or Nurse will assess members, usually in the clinic, but sometimes in the community with the Psychiatrist ultimately deciding if team outpatient supports are insufficient and inpatient treatment is indicated. Information was provided for members who experienced hospital admissions from August, 2015 through October, 2015, with the team involved in nine of ten psychiatric admissions, and one member self-admitting. Based on data provided, the ACT team is involved in approximately 90% of psychiatric admissions. Per staff report, the team is involved with 70-90% of admissions due to some members electing to not inform the team when they self-admit.	• Attempt to address barriers to the team not being involved in all admissions. For example, work with each member and their support network to discuss how the team can support members in the community, or to assist in a hospital admission, if the need should arise. • Ensure members and their informal supports have the team on-call, and staff phone numbers so they know who to contact for support if the need should arise. • See also recommendations for S4, S5 and S6.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	All staff interviewed report the team is involved in every member hospital discharge. Per report, discharge planning begins at first contact after a member is admitted. The CC reports staff meets with members and coordinates with inpatient Social Workers within 24 hours of admission. Staff then visit with the member at least every 72 hours during the inpatient stay. The ACT team facilitates doctor-to-doctor consultations between the inpatient and outpatient staff. After discharge, the team meets with members daily for the first five days, facilitates an appointment with the team	

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			Psychiatrist within 72 hours, and with the team Nurse within at least ten days, though the team tries to schedule the Nurse appointment within the first week after discharge. Information was provided for ten members recently discharged; the team was reportedly involved in planning for discharge in all ten situations.	
O7	Time-unlimited Services	1 – 5 (4)	There were two member graduations reported in the prior 12 months, with an estimated seven graduations in the next twelve months, or a 7% expected graduation rate. During the AM meeting observed there was discussion of members who may be appropriate for potential graduation (i.e., step down to a lower intensity of service – Supportive). Though the agency has a written *ACT Admission/Transfer/Discharge Desktop Procedure,* the team reportedly has utilized an informal process to determine member graduation readiness, but do note in the treatment plans if members are transitioning to a lower service level.	• The team should track admissions and discharges off the team to ensure members are not transitioned prematurely, allowing the team to develop a working relationship with members over time. • The ACT team should consult with the RBHA to determine if there is a discharge checklist, similar to the admission checklist, to utilize for system-wide consistency on ACT teams.
S1	Community-based Services	1 – 5 (3)	Staff confirm they have the resources to provide community-based services (including laptops, phones, company/clinic automobile for longer trips), but evidence indicates most member contacts occur in the clinic versus the community. Ten member records were reviewed to determine the ratio of community to office-based services. For those ten records, the median and mode value was 40% of face-to-face contacts in community. Only three of ten members received more than 50% of contacts in the community. Staff estimates they spend between 30-75% or more of their time in the community. The agency utilizes a report function that identifies the amount of community-based services staff	• The ACT team should increase community-based services to members. The agency should work with program staff to brainstorm ideas to increase community-based services and ensure those are documented accurately. Supportive housing services, assisting with employment goals, peer support services, individual substance abuse treatment, and other skill development activities should occur in the community rather than the clinic whenever possible. • Having multiple contacts in a brief period at the clinic may contribute to a higher frequency of contact (S5), but this can

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			provides; one staff reported she believed the goal was to be in the community at least 70% of the time but the report indicated she provided community-based services at a lower threshold. Some ACT team staff facilitates groups for ACT members at the clinic; it is not clear if these groups significantly limit staff ability to provide a higher level of community-based services.	negatively impact the ratio of community to clinic-based services, and possibly result in lower intensity of services (S4) due to the brevity of the contacts. • The ACT team should use sign in sheets for all groups. Other than the substance abuse groups, which the team should consider expanding and enhancing to increase member participation, review the member participation and satisfaction of other groups facilitated by ACT staff. The program should review the pros and cons of continuing to offer groups if member participation is low, versus spending the time in one-to-one interactions with members in their communities. • Consider using the on-call phone as the primary contact for staff even during regular business hours rather than relying on a team member "blue-dot" who is office-based. This may aid as the program transitions to provide increased community-based services, allowing staff to be in the field more.
S2	No Drop-out Policy	1 – 5 (5)	ACT staff report they retain members at a 98% rate; during the 12 months reviewed, two members moved from the area without referral. The team reported no other members left the team due to refusing services, due to the team not being able to locate them, or because the team determined that they could not serve them. This retention rate does not include members who transitioned off the team after placement in 24 hour residential treatment, and members who transferred to different ACT teams.	• Continue to monitor team referrals to residential treatment; weigh the pros and cons of referring members to residential treatment versus serving them though the ACT team.

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S3	Assertive Engagement Mechanisms	1 – 5 (5)	The team provided the reviewers a *Closure for Lack of Engagement Desktop Procedure* developed by the agency for staff to follow when members are out of contact with the team. The procedure outlines outreach activities that should occur over a six to 12-month timeframe, and notes that if contact is made, but the member declines to participate in treatment and does not attend an appointment with the Behavioral Health Medical Practitioner (BHMP) a minimum of every 90 days, the member's status is discussed with the clinical team prior to closure. Outreach activities include telephone calls, contact with natural supports, letters to last known address, contact with hospitals, jails, shelters, primary care physician, known providers, probation or parole if applicable, anyone who may provide special assistance, etc. Staff report the minimum timeframe for outreach prior to closure is six weeks, but the ACT team generally conducts a longer period of outreach, including visits to last know addresses with closing being the last resort.	
S4	Intensity of Services	1 – 5 (3)	The median intensity of service per member was 50 minutes a week based on review of ten member records. The average weekly amount of service time per member ranged from 8.5 to about 98.5 minutes, with five members receiving less than 50 minutes of direct team support on average per week. Some contacts were brief in duration, lasting only a few minutes. These brief interactions included when staff were greeting members at the clinic, with limited content topics discussed, different staff talking about the same issue with a member,	• Increase the intensity of services to members, optimally averaging two hours a week or more of face-to-face contact for each member. Explore what actions the team can take resulting in higher service intensity per member. For example, offering a spectrum of services directly by the ACT team rather than referring to external providers may result in higher intensity of services per member, maximize the full potential of the ACT team, and minimize the time spent coordinating with other brokered service providers.

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			or brief home visit contacts for medication observation support. One staff reported if a member receives medication observation, there may be frequent brief contacts, but the team may not spend quality time with those members since they are seen daily.	• See also recommendation for O3.
S5	Frequency of Contact	1 – 5 (3)	The median weekly face-to-face contact for ten members was 2.13 for each member based on record review. The average weekly face-to-face contacts with members over a month period ranges from .5 to 5.5., a mode of 2.5, and five members receiving less than two face-to-face contacts per week.	• Increase the frequency of face-to-face contact with members, not just those who receive medication observations, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support member goals.
S6	Work with Support System	1 – 5 (3)	Staff report that there is coordination with some informal supports only when members experience challenges. In review of CC documentation over a month period, the CC was in contact with informal supports, but as with other staff, documented contact with informal supports was usually initiated by those supports and not the team. Staff estimates of members with informal supports ranged from approximately 41-87%, and the average monthly frequency of contact with informal supports ranged from .82-5.33, with higher estimates based staff estimations for their individual caseloads assigned. In ten records reviewed there was an average of 1.4 contacts per member per month, and during the morning meeting the team discussed contact with informal supports for approximately 11% of members. Based on this information, it is estimated staff maintain approximately 1.6 contacts with informal supports per member per month.	• If a family member or other support is involved, continue efforts to coordinate with those supports when members are doing well and when members experience challenges. Establishing communication may allow the team to provide education regarding serious mental illness, and to enlist informal supports to advocate with members, if needed. • ACT staff should regularly review with members the potential benefits of allowing the team to engage their informal supports. These supports may include family, landlords, employers, or anyone else with whom members have consistent contact. If a member declines to allow staff to make contact with informal supports, this should be documented in the record. Review Health Insurance Portability and Accountability Act (HIPPA) guidelines when developing a team plan to engage informal supports in order to determine to what

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				extent staff can receive and share information with known supports if a member declines to provide a ROI. To align with agency practice, consider developing a desktop procedure to guide staff. • Consider developing a family psychoeducational group where families have the opportunity to expand their social networks, support each other, and learn techniques from each other on how to support members.
S7	Individualized Substance Abuse Treatment	1 – 5 (2)	The team SAS reported that monthly or every couple of months he meets with members who recently or currently use substances (estimated at about 20 members). Another staff estimated the SAS meets with about four or five people monthly. During the one-to-one contacts the SAS reported he talks about most recent substance use, triggers, coping skills, additional interests, and builds on getting them to a better place, or into treatment facilities. Documentation did not support individual treatment was provided when the SAS had contact with members with substance use challenges; the SAS did discuss participation in member run programs or the substance abuse group, but no evidence of formal treatment was identified. Staff generally invites members to the substance abuse treatment group as the primary substance abuse treatment option through the team, and the SAS reports the ACT team refers members out for more formal in depth treatment, with about 38% of members with current or recent substance use participating in an external treatment program.	• The program should ensure SAS staff are trained and receive supervision to provide substance abuse treatment, which should be provided primarily through the team. • The team, network, RBHA, and ADHS need to confirm whether unlicensed ACT staff in Arizona is allowed to provide individual substance abuse treatment. If unlicensed SASs can directly provide individualized treatment, ensure staff and programs receive guidance on the expectations, such as who must provide supervision to staff providing the service. • See recommendations for S9.

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S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	Per report, the SAS on the team facilitates an hour long treatment group once weekly. Staff report of how many members on the team who face co-occurring challenges ranged from one staff report of 49 members to one staff report of 20 members with active use. Staff consensus is that about five or six members (approximately 12%) attend the treatment group through the team at least once monthly. Substance abuse group curriculum developed by the RBHA is available and is sometimes utilized; the substance abuse group offered on the ACT team generally includes member check-ins, discussion of substance use, triggers, stressors, and the importance of quitting. Staff report some members are mandated to be referred to specific external programs through the correctional system.	• The team should review how they classify members with co-occurring issues due to the discrepancy in reporting. For those members not actively using, consider enhancing the current group or adding additional group times to focus on relapse prevention, remission, and recovery. The group may allow for member to member support to reinforce a sober lifestyle, offer members a venue to discuss how recovery impacts other areas of life (e.g., social, vocational, physical health), and if necessary, to provide mutual support in order to normalize relapse. • Consider implementing a sign in sheet to gain more accurate data on members participating in substance abuse treatment groups. • If members are mandated to receive substance abuse treatment, the ACT staff should attempt to educate the legal justice system regarding the spectrum of services that can be provided through a high fidelity ACT team, including co-occurring treatment groups, and individual substance abuse treatment. This may help to reduce referrals to outside providers for services that should be offered through the ACT team, and result in higher intensity of services through the team. • See recommendations for S9.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	It does not appear that the team employs a consistent stage-wise treatment approach based on documentation and interview report. The SAS is not familiar with a stage-wise treatment approach,	• Train staff in a stage-wise approach to treatment; interventions should be aligned with a member's stage of change. Integrated dual diagnosis treatment

Item #	Item	Rating	Rating Rationale	Recommendations
			though the CC was familiar with the stages of change model. Staff had difficulty identifying a specific treatment model; one reported the team uses a recovery based model, and one did not identify a specific model. Agency treatment plans include language from the stages of change model when describing current and desired measures for all identified areas to be addressed, not only those pertaining to substance use, and some Psychiatrist documentation includes references to stages of change. Staff makes contact with members to discuss substance use and talk about symptoms, but appear to primarily offer only the substance abuse group. The team relies on referrals to outside agencies for more formal individual substance abuse treatment, including group support, and residential treatment. Staff was inconsistent in reporting the team view of abstinence versus harm reduction tactics. One staff reported the team encourages abstinence from illegal drugs, but added that some members may not be able to take the step to quit all at once. Another staff reported the team utilized a harm reduction approach, encourages members to cut back if they can, encourages meetings and group participation for members to utilize coping skills, and that the Psychiatrist may prescribe medications to help with cravings. The SAS reported there are no coordinated trainings or meeting with other ACT SAS staff, but noted it may be helpful to meet with other ACT SASs on other ACT teams to share ideas. The team may refer members to AA if they feel it is something that may help. The team may refer	training on a recurring basis may empower SAS staff across the agency to support members in a consistent manner, based on a proven model. If conducted at the agency level, the collaborative meetings may also allow the opportunity to provide group supervision and guidance to ACT SASs. The RBHA and agency should work collaboratively to explore training and supervision options. • Once trained in an integrated dual diagnosis treatment model, empower SAS staff to cross train other ACT staff. Revise program language when describing member substance use (e.g., avoiding the words “clean” or “dirty”).

Item #	Item	Rating	Rating Rationale	Recommendations
			members to detoxification, but did not have recent examples of these referrals.	
S10	Role of Consumers on Treatment Team	1 – 5 (5)	Members with lived experience of mental illness are employed on the team full-time, with full professional status; the ACT team has an identified PSS. Though not all members are aware of the PSS on the team, the PSS reports she discloses to members depending on the situation, if it is relevant to what the member is experiencing.	• Provide members with staff names and contact information, and consider including descriptions of positions and duties in order to familiarize members to the ACT team staff composition.
Total Score:		**3.61**		

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	4
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	4
9. Substance Abuse Specialist on Team	1-5	1
10. Vocational Specialist on Team	1-5	2
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	4
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	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.61**	
Highest Possible Score	**5**	