ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Jill Rowland

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ADHS Fidelity Reviewers

Method

On July 21, 2014, and July 22, 2014, David Lynde, Mimi Windemuller, Jeni Serrano, Georgia Harris, Karen Voyer-Caravona, and T.J. Eggsware completed a fidelity review of the Choices Enclave 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 Choices Provider Network Organization (PNO) serves over 7,000 Maricopa County residents diagnosed with a serious mental illness. The Choices Enclave clinic is located in Tempe, AZ with clinic services including ACT, family and peer mentoring, and other activities provided by Choices staff as well as co-located providers. The Choices Enclave clinic was located in an accessible location, and the layout of the agency allowed for various clinic sponsored and co-located provider activities/services to occur. At the time of the review, the Enclave clinic ACT team reported 86 members were served and was fully staffed.

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

- Program overview discussion and interview with the leader of the ACT team.
- Observation of a daily ACT team meeting.
- Individual interviews with the identified ACT team Substance Abuse Specialist, and two other staff on the ACT team (Transportation Specialist and the team's second Substance Abuse Specialist).
- Interviews with 11 members served by the ACT team.
- Charts were reviewed for 10 members served using the agency's electronic medical records system, with assistance from the leader of the ACT team.

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 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 member to team staff member ratio was less than 10:1.
- The ACT team meets at least four days/week and reviews each consumer each time, even if only briefly.
- At least one full-time psychiatrist was assigned to the program.
- At least ten FTE staff were assigned to the program.
- The program recruited a defined population and all cases complied with explicit admission criteria.
- The ACT team provides 24-hour coverage.
- The ACT team is involved in planning for hospital discharges.
- All members served on a time-unlimited basis, with fewer than 5% expected to graduate annually.
- The ACT program demonstrated assertive engagement mechanisms, including consistently well-thought-out strategies, street outreach and legal mechanisms whenever appropriate.
- The Peer Specialist on the ACT team has full professional status.
- The ACT program functions with a team approach.
- The ACT team operated at near full staffing over the period reviewed.
- The ACT team intake of members generally occurred at a low rate to maintain a stable service environment.
- The ACT team directly provided psychiatric services and medication management, rehabilitative services, and some housing support in addition to case management services.
- The ACT team was involved in the majority of the applicable admissions reviewed.
- The ACT team has a no drop out policy, and the team engaged and retained members at a mutually satisfactory level.

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

- Formal and structured substance use treatment –
    - At the system, network and clinical level, ensure all staff involved in substance use treatment activities have received training, education, support and ongoing supervision related to substance use treatment models.
    - At the ACT team level, consider implementing a structured stage-wise treatment approach that includes treatment stages, interventions, and activities for intervening staff, such as Integrated Dual Diagnosis Treatment (IDDT).
- Ensure group treatment is based on a proven and structured model, and provide individualized substance abuse treatment through the team. It was not clear if the ACT team emphasized skill development and support in natural settings, especially regarding vocational services that enable members to find and keep jobs in integrated work settings.

    - At the network and clinic level, ensure all staff involved in vocational support activities has received training, education, support and ongoing supervision related to provision of those services.
    - Ensure vocational supports on the ACT team assist members with rapid access to employment rather than relying on referrals to outside providers.
- There was one nurse assigned the team, but the nurse reportedly spent some time providing services to members from other teams. Explore options to add a nurse, so that two full-time nurses are available for a 100 member program (at full capacity). This would allow the nurses additional flexibility to provide services (i.e., one nurse remaining in the clinic, and one in the field).
- The program might consider working toward more time assisting members to develop skills in the community rather than functioning as an office-based program. This will help ensure that contacts are primarily occurring in natural settings.
- Based on information reviewed, it appeared the supervisor spends a large amount of time on administrative and supervisory duties, providing direct services to members on rare occasion or as backup. It is recommended that at least half of the supervisor's time be spent providing direct services.
- The team should consider focusing on increasing the amount of face-to-face contacts, as well as service time, per member.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	(1 – 5) 5	Per interview report, the Choices Enclave ACT team has been fully staffed for approximately three to four months, and provided services to 86 members at the time of the review. The team staffing was reported to be 11 staff line positions. In determining member to team staff ratio, staffing included the identified substance abuse specialists, employment specialist, nurse, and ACT leader, but excluded the psychiatrist and administrative support staff. The member to staff ratio fell below 10:1.	• The agency and the ACT Team Leader should continue to monitor and manage the team's caseload to keep the ratio below 10:1.
H2	Team Approach	(1 – 5) 4	Based on staff and member interviews and reviewing clinical records, it appeared team services were generally provided by a specific Case Manager, not necessarily based on member need. Staff report related to member contact varied, but included the report of at least one face-to-face contact was expected per week per member, and a minimum of two contacts per month in the member's home with approximately 90 – 95% of members receiving at least one face-to-face contact each week. Staff also reported having an assigned caseload, with limited reference to a shared caseload across the entire team. Those members interviewed generally identified one primary staff contact (Case Manager), but did not consistently report contact with other team members other than the psychiatrist, but some indicated an awareness of other team staff members who could be contacted if the need arose. During the daily meeting observation on 7/21/14, there were several references that	• Review team approach to contact, to ensure contacts occur with a variety of staff members rather than contact based on caseload assignment. • If primary caseloads are assigned for specific paperwork related tasks, ensure the specialty staff are able to perform in their specialist role as a primary function on the team. Preferably, staff would not have individual caseloads, but the team as a unit would be responsible for service provision to support members. • Continue efforts to provide services to members with primary consideration for need and staff specialty versus general caseload assignment in order to ensure a variety of team members are involved in each member's care. • Review team approach to individuals who are hospitalized to ensure contact

			various team members were involved in member services and collaborated across disciplines. Additionally, there were examples contact was planned based on need rather than caseload assignment (for example, the team leader requesting the Independent Living Specialist (ILS) make contact with a member to address self-care of the member related to maintaining their residence.) The member records reviewed were the primary data source, and they ranged from zero to nine face-to-face staff contacts, with a mode of three contacts over the applicable two-week period. One of the two individuals who received zero contacts over the two-week period was hospitalized over the timeframe. It was determined 70% of members reviewed met with more than one staff member over the two-week period.	occurs at least weekly per month, preferably with various team members involved in face-to-face contact and coordination activities.
H3	Program Meeting	(1 – 5) 5	Per interview report, the team meets every week day except for Saturday and Sunday, with one day allocated for team staffing. Starting shifts are staggered from 7:30AM through 10:00AM to allow staff to complete service activities (e.g., medication observation) in the AM and PM hours. It was reported all team members served are discussed at each daily meeting. Reviewers observed the team daily meeting on 7/21/14, where a tracking form listing the members served was utilized. The form appeared to include up to date information based on the noted dates listed in correlation to the member status discussions. Some of those discussions appeared to be based on recent contacts or attempted contacts related to medication observation services. Reviewers also observed evidence of cross discipline coordination of activities that had occurred from approximately one day to up to one week prior for each individual. Member records reflected notes of	• Review team and network expectations for team meeting documentation in member records regarding content and action steps for each person discussed. Preferably, the documentation would include the specific topic discussed, action item/s, and assigned person/s to carry out the task.

			daily meeting discussions; however, the content of those discussions was sometimes limited to simple references that the member had been discussed.	
H4	Practicing ACT Leader	(1 – 5) 2	The ACT leader's time includes approximately 50% administrative activities. One day a week, the team leader, psychiatrist and nurse on the team go into the field and meet with approximately three to four individuals. Per report, it was estimated the team leader spent approximately 30% of her time performing client contacts. An encounter report/productivity record corresponding to the month the ten member records were reviewed indicated less than one half hour per week of direct team leader service (actual service time not billed time) was provided, on average. In the ten member records reviewed, one team leader hospital contact was noted. Note that member screenings are not considered direct service because the member is not actually a part of the ACT team at that point.	• Review team leader administrative activities to determine if all are essential and required through the involved stakeholders or other oversight entities. • If all leader administrative activities are deemed essential, consider if there are other supports at the clinic that could assist in completing some or all of those tasks which may allow the team leader to provide increased direct service to members. • If all identified administrative functions are required, team leader responsibilities may be an area of further review to determine if action should occur at a system level. The need for this level of intervention cannot be fully confirmed at this time.
H5	Continuity of Staffing	(1 – 5) 3	It was determined over a two year period, 25 staff had filled the available 13 staff line positions. The staff turnover rate fell within 40-59% over the two year period.	• Consider exploring the reasons employees cite for making a change in position that leads to staff turnover. This may be an area of further ongoing network, clinic and system review.
H6	Staff Capacity	(1 – 5) 4	The ACT team has been fully staffed for the last three to four months prior to the review. It was noted staff vacancies over a year period ranged from approximately one to four positions per month, with the peak vacancy rate September, 2013. Over the 12 month period, there were 23 vacancies. The program operated at 80-94% of full staffing over the 12 month period.	

H7	Psychiatrist on Team	(1 – 5) 5	Per interview with the team leader, a full time psychiatrist was assigned to the team. Per discussions during the daily meeting, it was noted that a portion of the psychiatrist's time may be spent meeting with members from other teams at the clinic. Per report, the amount of time could vary, and could be impacted by the availability of other psychiatrists at the clinic to meet with individuals who may be under Court Ordered Treatment (COT) and are required to meet with a psychiatrist at least monthly.	• As the team caseload rises, review ongoing clinic monitoring of psychiatrist coverage to minimize the number of non-ACT members that are served by the ACT psychiatrist, ensuring that at least one full-time psychiatrist is assigned directly to a 100-member program.
H8	Nurse on Team	(1 – 5) 3	Per discussions during the daily meeting and the team leader interview, it was noted that a portion of the nurse's time may be spent meeting with members from other teams at the clinic (estimated 10-20% of the nurse's time). It was reported that the nurse's schedule is generally more open than the psychiatrist's, with one possible reason being that members may not want to meet with the RN if not viewed as necessary. However, the nurse was willing to go into the field to provide services (e.g., injections). As noted previously, one day a week the psychiatrist, nurse and team lead go into the field to make contact and provide services with members. It was also reported that during the summer months, the nurse goes into the field two times a month to visit individuals in Supervisory Care Homes (SCH) and one day during the other months of the year. The ACT team leader reported there is one nurse employed on the ACT team.	• Review options to educate and engage individuals to meet with the nurse. • Review clinic nursing coverage options to allow the ACT team nurse additional flexibility to engage individuals in the community which may allow the nurse to assess members more frequently, and in turn educate the team about important medication issues that a nurse may identify. • As the team caseload rises, monitor of clinic nurse coverage options to mitigate the number of non-ACT members that are served by the ACT nurse, ensuring that at least two full-time nurses are available for a 100-member program. • Review options to add a nurse, so that two full-time nurses are available for a 100 member program. This would allow the nurse additional flexibility to provide services (i.e., one nurse remaining in the clinic, and one in the field).
H9	Substance Abuse Specialist on Team	(1 – 5) 1	There are two staff with the designation of Substance Abuse Specialists (SAS) on the team.	• Review training and supervision options to ensure staff identified in the

			The staff identified in the SAS role reported minimal experience working with individuals who may have experienced substance use challenges. However, neither has specialized training working with clients with co-occurring substance use and mental illness. There is no evidence that both substance abuse specialists received one year of substance abuse training or supervised substance abuse treatment experience that supported the staff achieved a level of expertise in the area. Staff also reported having an assigned caseload with associated responsibilities (i.e., paperwork activities) in addition to their role as a Substance Abuse Specialists.	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). • Review Substance Abuse Treatment responsibilities for caseload coverage that may impact the ability of the identified specialists to focus on their specialty role.
H10	Vocational Specialist on Team	(1 – 5) 1	There is one staff member who is charged with providing vocational services, and an additional staff was identified as a Rehabilitation Specialist who focused on member community integration. It was reported that the vocational staff on the team refers employment services out to other agencies (e.g., Vocational Rehabilitation or Supported Employment provider). It was reported that 15 members of the team were working, and that the team and Benefits Specialists worked with members to aid in increasing member awareness of the option to work, how much could be earned, and to discuss programs such as Freedom to Work. The ACT team does not appear to provide individual employment services focused on directly assisting members in job search and sustained employment in integrated work settings, and it was not clear if the identified staff had received education to successfully fill the role of vocational specialist.	• Review the referral process for vocational services to determine if the ACT team may provide vocational services directly rather than referring to a supported employment provider. Attempt to identify potential system barriers to the ACT team directly proving vocational services. • Review training and supervision options to ensure staff identified in the role of Vocational Specialists receive support, monitoring, and education in the role for the population served (i.e., adults diagnosed with a serious mental illness). • Review Vocational Specialist responsibilities for caseload coverage that may impact the ability of the identified specialists to focus on their specialty role.
H11	Program Size	(1 – 5) 5	Per team leader interview, and documentation provided, the team consisted of more than 10 full time equivalent staff.	

O1	Explicit Admission Criteria	(1 – 5) 5	Per interview report, members may come to the ACT team from a number of sources, including: hospitals, other clinics without ACT teams or from an ACT team from another clinic. Per report, the team was fully staffed for approximately three to four months prior to the review. There were seven members admitted to the team in June, 2014. The team leader is primarily responsible for the initial screening of an individual prior admission to the ACT team. The team utilizes a standard ACT Team Eligibility Criteria form for the initial step in admission to the team, which reflected the program had a clearly identified mission to serve a particular population, using measurable and operationally defined criteria to screen out inappropriate referrals. The team leader reported she also meets with the proposed member (one to approximately three times) to determine if the individual does or does not meet ACT criteria. The ACT team doctor ultimately determines if the person will be admitted to the team, based on the written criteria and the information gathered from the team leader's contact with the member.	• Ensure any second level assessment completed by the team leader is applied consistently in a formal manner, after the initial Eligibility Criteria is confirmed, in order to ensure all cases comply with explicit admission criteria. • Continue recruitment efforts through the reported sources, as well as through other avenues (e.g., contacts with hospital social workers, probation or parole, or other community contacts).
O2	Intake Rate	(1 – 5) 4	Per interview report, individuals are admitted to the team at approximately two to three per month, and it was estimated that there were approximately seven to eight new members admitted to the team over the six months prior to the review. During the daily meeting observation, two new team member admissions were discussed, with discussion of pertinent needs (e.g., medical challenges) for one of those individuals. It was reported that prior to full staffing on the team, members had been transitioned to another ACT team within the network. Per documentation, the team was fully staffed for approximately three to four months, and over the six months prior to the review, intakes to the team reportedly ranged	• Review what may have occurred in the month of June, 2014 that resulted in the intakes rising above six, and explore solutions to ensure the intake rate falls within the reported range of two to three per month until the member caseload reaches preferred capacity.

			from one to seven per month. The highest single month intake rate over the six month timeframe was seven for June, 2014.	
O3	Full Responsibility for Treatment Services	(1 – 5) 4	Per interview report, three members reside in privately paid group homes. For those individuals, it was reported the team coordinates with the home staff, but the ACT team provides case management and other related services. Per interview reports and documentation, it was confirmed that the ACT team directly provided psychiatric services and medication management, housing support and rehabilitative services in addition to case management services. Housing support included services focused on independent living and ACT housing. Conversely, it was reported during a staff interview the ACT housing could be considered transitional. Also, during the daily meeting observation, it was noted that a person could be moved from one unit to another to accommodate another member of the team. Based on interviews, observation, and record review there was some evidence that housing support was provided. It was reported the team did not provide counseling, referring the service out, with one specific provider identified. It did not appear that the team provided substance abuse treatment or employment services primarily. It was reported that vocational services are most often provided through referral to an outside organization. It was reported that staff in the role of Rehabilitation Specialist focused on community involvement. Substance use treatment referrals were also made to outside providers (e.g., TERROS) per report. When outside providers were involved, it was reported that monthly reports were provided to the team. Overall, there was evidence the team provided three or four of five additional services and referred externally for	• Review team services to ensure as many as possible are provided through the team rather than referring to outside providers such as supported employment. • If it is determined in the best interest of the member to refer to a provider outside of the ACT team, ensure all available options to meet the need of the member are explored. • If it is determined in the best interest of the member to refer to a provider outside of the ACT team, ensure the need and expected benefit of the service is clearly documented. In addition, ensure documentation outlines the specific support the outside provider will provide that the ACT team cannot provide. • When discussing available housing supports and options, ACT housing may be appropriate, but consider other available options in the community with supports to the person to maintain living in the least restrictive environment provided through the ACT team, such as support through the team ILS, Housing Specialist (HS) or other team members based on individual need. This may include actively pursuing other options outside of the ACT team apartment units, Section 8 or residential settings. • Review the referral process for

			others.	vocational services to determine if the ACT team may provide vocational services directly rather than referring to a supported employment provider. Attempt to identify potential system barriers to the ACT team directly proving vocational services.
O4	Responsibility for Crisis Services	(1 – 5) 5	The ACT team provides on call coverage. After 7PM the members call the ACT on call cell, the primary CM, or the crisis line who patch the calls to on call ACT cell if the computer identifies the member as receiving services from the ACT team. It was also reported the ACT team leader is the back-up staff member who is on call, 24 hours a day, and seven days a week.	• It is recommended that the agency and the ACT team continue to use a structure that affords ACT clients access to ACT team members during weekends and evening hours.
O5	Responsibility for Hospital Admissions	(1 – 5) 4	It was noted the team was involved in eight of 12 admissions reported. The team was involved in 67% of the identified admissions. It was reported that the team was not consistently informed of all admissions, sometimes receiving notification days after the event.	• Ensure consistent contact is maintained with all members served, which may result in the identification of issues or concerns that could lead to potential hospitalization. Consider requiring the potential for hospitalization to be assessed at each contact, to include possible danger to self, others, or ongoing persistent behaviors that could lead to hospitalization. • This may be an area of further review at a system level to determine if the teams could be notified of member contact at hospital locations, prior to admission, to potentially intervene or prevent the admission.
O6	Responsibility for Hospital Discharge Planning	(1 – 5) 5	During daily meeting there was some discussion of hospital discharge planning. Members who were inpatient, or who had recently experienced an inpatient experience, were discussed in the daily	• For individuals who are hospitalized, ensure at least minimum expected contact is maintained at a frequency consistent with any applicable clinic,

			meeting. In the applicable member records reviewed of individuals who experienced an inpatient hospitalization, there was evidence of attempted and completed coordination with hospital staff (e.g., inpatient Social Worker) as well as coordination with clinic management. In some cases documentation related to coordination with involved support staff was more detailed than the direct contacts with members related to discharge planning. As noted previously, in one record reviewed a person who was hospitalized did not appear to receive staff face-to-face contact consistently as evidenced by a two week timeframe with no documented ACT team contact. For the member, contact was not in alignment with reported required contact expectations (per staff interviews) of at least one face-to-face contact per week with each member of the ACT team. As part of the review, ten individuals who experienced a hospital discharge were identified, and the ACT team leader reported the team was fully involved in all ten of the discharges.	provider network, or governing body requirements. • Ensure members are engaged to the maximum extent possible in developing their discharge plan so that discussions with the member are commensurate to planning discussions with inpatient and outpatient supports.
O7	Time-unlimited Services	(1 – 5) 5	Per team leader report, no members had graduated (i.e., need for services was reduced) in the twelve-month period prior to the review, but approximately three to four people a year were expected to graduate.	
S1	Community-based Services	(1 – 5) 3	Ten member records were reviewed to determine the ratio of services delivered in the community versus those delivered in the office. There was some indication the team relies more on services or service providers that may be based in the clinic setting. Of the ten member records reviewed, the percentage of community contacts ranged from 20% to 100% with a median of 57%.	• Ensure efforts are made to provide services, through the ACT team in the community, rather than providers in the clinic setting. • Member services (e.g., crisis services, medication observation, assessment of the member, direct assessment of the residence) may be delivered more effectively through home visits, so this should be explored throughout the

				team. • Review referral locations to determine if other providers may be involved in activities that should fall under ACT services. • Team leader should routinely review charts and staff schedules/time to ensure a majority of member contact is made in community settings.
S2	No Drop-out Policy	(1 – 5) 4	Per documentation provided, in the twelve months prior to the review, one member declined services, two members could not be located, four members were transitioned to a lower level of care, and two members transitioned to a lower level of care due to placement in a residential program. Some members were transitioned from the ACT team if placed in residential treatment, when a 30-day transition timeframe was reported. The ACT team maintained 80-94% of the caseload over the 12-month period reviewed.	• If the team determines that a member would benefit from residential treatment, or another service that the team feels it cannot adequately provide, ensure documentation outlines the specific support the provider will offer that the ACT team cannot provide. On a case-by-case basis, consider the impact of transitioning a member from the ACT team, with consistent support, to a new residential and treatment team and whether that transition is in the best interests of the member. • Further systematic review may be beneficial to determine if a temporary residential placement may occur in conjunction with ACT services rather than disrupting the member's relationship.
S3	Assertive Engagement Mechanisms	(1 – 5) 5	Member engagement mechanisms included medication observations, assessment for involuntary outpatient treatment, efforts to arrange for assessment through the team psychiatrist, and if concerns were identified, the pursuit of court ordered treatment (COT) through	• Ensure the team continues to utilize assertive engagement mechanisms so that member admission to the ACT team may occur at a rate that is reasonable for a fully staffed team, and in accordance with information

			the mental health petition process. In addition, it was reported the team filed amendments to active COT orders if it was determined a person was not attending appointments as scheduled with the psychiatrist, or taking medications as prescribed. Per report, 33 of the members served were under an active COT. During interviews, there was some indication that options offered to individuals could include contingencies, not specified as a requirement (e.g., sobriety in order to access ACT housing), but may be strongly encouraged. It was noted that in those situations, staff would attempt to engage an individual to address an identified challenge. It did not appear that members were discharged from the program due to failure to keep appointments. Additionally, there was discussion in the daily meeting of efforts to outreach and engage individuals, as well as specific interventions and options that could be explored (e.g., eating disorder treatment program). It was reported that if a member were to ask to end treatment, the team may request a 90 day period prior to making the final decision to terminate treatment through the ACT team.	outlined under area O2 above. • Ensure efforts are made to avoid coercive treatment, in order to support member choice to the maximum extent possible.
S4	Intensity of Services	(1 – 5) 2	During review of ten member records, the sum of face-to-face service time was determined for each member, which was then calculated as an average for each member. The median face-to-face service minutes across the ten member records fell within a range of 15 – 49 minutes per week. There appeared to be some discrepancy between the actual weekly average service minutes found in member records, and the depth of conversation in the daily meeting. As noted previously, during the daily meeting, there was cross discipline discussion of member status, with a high number of individuals that appeared to be in contact with more than one ACT team member. Final scoring	• Review documentation expectations to ensure all face-to-face contacts are documented. • Review potential barriers that may prevent staff from higher face-to-face service time spent with members. • Consider what actions the team may take (e.g., reduction of referrals to outside providers, increase in services through the ACT team) that could result in higher service intensity per member. • Team leader should periodically review

			was based on data found in member records.	member records and staff schedules to ensure appropriate face-to-face contacts are being made.
S5	Frequency of Contact	(1 – 5) 2	Per interview report, it was noted that weekly face-to-face contact was expected, with two home visits per month per member. Members interviewed generally referenced contact with specific staff, with some referencing at least weekly home visits. During interviews with staff, it was reported that member face-to-face contact was to occur weekly, with home visit contact bi-weekly (i.e., two times per month). There was consistent information per staff and member interviews to support the minimum expected frequency of face-to-face contact was one per week per member. Ten member records were reviewed to gather the actual number of face-to-face contacts with team members over a month period, from which the median number of weekly face-to-face contacts was derived. The median face-to-face contact was 1.25.	• Review contact expectations to determine if the minimum of one face-to-face contact per member is adequate. This includes review of team and possible system barriers to maintaining frequent face-to-face contact with members. • Team leader should periodically review member records and staff schedules to ensure appropriate face-to-face contacts are being made.
S6	Work with Support System	(1 – 5) 1	During the daily meeting observation, there was some discussion of informal supports (e.g., guardians, uncle, ancillary contact with a member's mother, and discussion of a husband with whom the team had not made contact). Consistent contact with support systems was not documented in the ten member records reviewed, for the month period reviewed. During staff interviews, there was some reference to contact with information supports, with one member referencing contact with supports at times with 50% of the specific staff's assigned caseload. When asked, members did not consistently report the ACT team was in contact with identified support systems (e.g., family, landlord, shelter staff, employers, or other key supports). Based on	• As a component of service provision, be sure ACT staff is reviewing the potential benefits with members that can come from the engagement of informal supports. • If a member has an identified support system, efforts should be made to involve that system. If a person has other supports involved, but the person declines to allow the team to engage those supports, this should be documented along with follow up conversations revisiting this decision with pros and cons at a later date. • If a support contacts the team, it would

			available information, across the 86 members served on the team it appeared the team maintained less than .5 contacts per month for each member with a support system.	generally be appropriate for the ACT team to receive information from the support.
S7	Individualized Substance Abuse Treatment	(1 – 5) 1	Staff did not report individualized substance abuse counseling sessions are provided through the ACT team. It was reported that some members go to Phoenix Interfaith for general counseling, but there was some discrepancy among staff as to whether the provider addressed substance use or provided only general counseling services (e.g., grief, coping skills).	• Review team, provider, and system options related to securing or training staff to provide individual substance abuse treatment in a structured manner. • See also recommendations in S9.
S8	Co-occurring Disorder Treatment Groups	(1 – 5) 2	It was reported that 52- 53 of the 86 members served by the team had a substance use disorder. The staff identified in the role of Substance Abuse Specialists held two substance use treatment focused groups per week, for one hour each. There was some discrepancy in the reported number of individuals from the ACT team who attended each group, with a total of six to eight members each week across the two groups, approximately two to three members in each group from the ACT team, with three or four members from the ACT team who may attend groups sporadically.	• Review the substance use treatment groups curriculum to ensure a co-occurring disorders treatment model is utilized. Several good manuals contain curriculum and strategies to engage clients in co-occurring stage-wise treatment groups. • Ensure staff designated to provide co-occurring treatment focused groups coordinate the content of the groups, track attendance at each group, and lead coordination of services related to substance use treatment on the team.
S9	Co-occurring Disorders (Dual Disorders) Model	(1 – 5) 2	Staff identified in the role of Substance Abuse Specialists held two substance use treatment focused groups per week, for one hour each. Topics addressed may include barriers, stereotypes, mindfulness, relaxation, goal setting, strategies to manage anxiety, but may also be based on whatever topic the members wanted to discuss. The two staff identified in the role of Substance Abuse Specialists have not yet developed a cohesive curriculum for groups. There	• Review options to implement a stage-wise treatment approach, at the team, clinic, network and system levels. Standardizing basic tenants of the treatment may help to ensure consistent interventions across the system.

			was also evidence of referral to outpatient providers for substance use treatment.	
S10	Role of Consumers on Treatment Team	(1 – 5) 5	The Peer Support Specialist (PSS) was identified as a full time member of the team and was noted to be a core team member. During the daily meeting, the identified PSS on the team was an active participant and was actively involved in outreach, member contacts, and service delivery that included medication observation activities.	• Continue to fully include and support the ACT Team's Peer Specialist as a full team member with full professional status.
Total Score:		**3.46**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	5
7. Time-unlimited Services	5
Nature of Services	
1. Community-Based Services	3
2. No Drop-out Policy	4
3. Assertive Engagement Mechanisms	5
4. Intensity of Service	2
5. Frequency of Contact	2
6. Work with Support System	1
7. Individualized Substance Abuse Treatment	1
8. Co-occurring Disorders Treatment Groups	2
9. Co-occurring Disorders (Dual Disorders) Model	2
10. Role of Consumers on Treatment Team	5
Total Score	**3.46**