ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: March 8, 2018

To: Frank Scarpati, Chief Executive Officer
Safdar Chaudhary, MD, ACT Psychiatrist

From: Karen Voyer-Caravona, MA, LMSW
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AHCCCS Fidelity Reviewers

Method

On February 6 – 7, 2018, Karen Voyer-Caravona and Annette Robertson completed a review of the Community Bridges, Inc. Avondale 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 CBI Avondale ACT team is located at 824 N. 99th Avenue in Avondale, Arizona. In addition to the Avondale ACT team, CBI operates the 99th Avenue ACT team and three Forensic Assertive Community Treatment teams (F-ACT). At the Avondale location, CBI also offers: primary healthcare services; triage, assessment, brief intervention, and transition support through Access Point; and short-term stabilization services through Transition Point.

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 on Tuesday, February 6, 2018;
- Individual interview with Team Leader/Clinical Coordinator (CC);
- Individual interviews with a Substance Abuse Specialist (SAS), the ACT Specialist (AS), and the Rehabilitation Specialist (RS);
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Review of agency provided documents including: resumes and training transcripts for the SASs, Employment Specialist (ES), and RS; *RBHA ACT Eligibility Screening Tool* and *ACT Exit Criteria Screening Tool*; *CBI On-Call Policy*; sign-in sheet for co-occurring groups for a recent month timeframe; individual substance abuse treatment encounter reports for both SASs, and the face-to-face encounter report for the CC.

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 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:

- Role of consumers on the team: Not only does the ACT team have a dedicated Peer Support Specialist with responsibilities equal to those of the other direct service staff, but numerous ACT direct service staff have lived experience in recovery. Several staff interviewed described how their own recovery informs their ability to build trust and rapport with members. Members interviewed discussed the value they placed in peer support provided by the staff who disclose their recovery journeys, validate their experiences, and inspire hope.
- Substance Abuse Specialists: The ACT team has two substance abuse specialists with graduate level education in counseling and training and experience to deliver both individual and group substance abuse treatment. Interviews and documentation suggest knowledge and skills to cross-train and mentor other specialists in co-occurring treatment.
- Full responsibility for treatment services: In addition to case management, the ACT team is responsible for providing members with psychiatric services, general counseling/psychotherapy, substance abuse treatment, housing support, and vocational/employment assistance and support.

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

- Continuity of staffing: In the past 24 months, 11 people left 12 positions on the ACT team for a turnover rate of 46%. Five people have worked in the SAS position during that period; in the last year, three Psychiatrists provided coverage prior to that position being filled. In order to support therapeutic trust and rapport between ACT staff and members, efforts should be made to retain staff for a turnover rate of less than 20% in two years.
- Frequency of contact: Per a review of ten randomly selected member records, members received an average of 2.5 contacts with ACT staff per week. Travel time, required to engage members living across a vast geographic catchment area, was noted as a factor contributing to lower intensity services and frequency of contact. The ACT team should review current strategies used, as well as those employed by teams that have done well in this area, with the goal of increasing frequency to an average of four member contacts weekly across the team.
- Work with support system: Staff said they have at least one weekly contact with an informal support of each of the approximately 40% of members with an informal support system. The record review showed that staff had one contact a month with an informal support per member. The team should work toward four contacts each month for each member with such.
- Co-occurring treatment groups: The SASs provide two co-occurring groups weekly; one is geared at early change stages through preparation, while the other is focused on action through maintenance stages, with an average attendance of approximately five

members each. Staff said that all specialists are trained to engage members in discussions about substance use and offer co-occurring groups, though it appears some staff rely on more traditional 12-Step approaches. Per data provided by the ACT team, 19 (28%) unique members attended at least one co-occurring treatment group in a month period previous to the review. ACT staff should collaborate on strategies to motivate engagement in these groups, with the goal of increasing attendance of COD groups to 50% of members identified with a COD.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, the ACT team had 11 staff (excluding the ACT Psychiatrist) serving 90 members for a staff to member ratio of 8:1.	
H2	Team Approach	1 – 5 5	Per a review of ten randomly selected member records, 90% of members had contact with more than one ACT staff member in a two week period. The CC tracks staff/member contacts daily at the program meeting. Most members interviewed said that they regularly see multiple ACT staff during the week and can receive services and support by any specialist, including the CC. Staff interviewed said that they carry *paperwork* caseloads of up to ten members, and are responsible for ensuring certain documentation requirements, such as annual reviews, are completed.	
H3	Program Meeting	1 – 5 4	The ACT team conducts program meetings on Monday, Tuesday, Thursday and Friday. Updates, including staff/member contacts, presentation, emerging needs, outreach status, housing situation, physical health concerns, crises, and hospitalizations are discussed. On Wednesdays, the team discusses specific cases in more depth, conducts scheduled staffings, or receives supervision or cross training. In the program meeting observed by the reviewers, the CC led the meeting, providing direction and prompts for action steps for next engagement, as well as mentoring and suggestions using his own lived experience to illustrate challenges members may experience with acknowledging substance use. All	• The ACT Psychiatrist should attend at least one program meeting weekly where all members are discussed.

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			staff in attendance participated actively, and all members were discussed. Accounting for the score is that the Psychiatrist does not attend any program meeting and only attends the Wednesday staffing by teleconference.	
H4	Practicing ACT Leader	1 – 5 4	The CC provides the same types of services and contacts with members as those of the specialists who report to him. Those contacts include: individual supportive counseling, group psychoeducation/skill building treatment, medication observation and education, crisis intervention, and assistance with tasks such as completing housing applications. Members interviewed report regular contact with the CC. Though the CC estimated that 20% of his time is engaged in face-to-face contact with members, a review of the CC's real time encounter log showed 33%. Per the record review, out of 11 direct service staff (excluding the ACT Psychiatrist) the CC was responsible for 9% of the contact time provided by the team. Actual time recorded appeared to be rounded to the nearest five minutes, and there were no notes less than 10 minutes.	• Continue efforts toward the CC spending at least 50% of his time providing face-to-face member services. This may be done in the context of shadowing and mentoring specialists in the field. • Identify and find solutions to any barriers to reaching and maintaining at least 50% direct member contact, including reassigning administrative tasks that could be performed by other staff.
H5	Continuity of Staffing	1 – 5 3	In the 24 months preceding this review, 10 staff worked in 12 positions for a turnover rate of 42%. Some positions were turned over multiple times or were covered by staff from other ACT teams while they were vacant. Per interview, it appears that some staff who left may not have been a good fit for the ACT model of service.	• Hire and retain qualified staff; vet candidates thoroughly to ensure they are the best fit for the position and the demands of an ACT level of care. • Consider, through exit interview and employee survey, identifying reasons for turnover as well as retention.
H6	Staff Capacity	1 – 5 4	For the 12 months prior to the review, the ACT team had a total of 10 open positions. The positions of Psychiatrist and Nurse stayed vacant the longest (three and six months respectively).	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually.

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			The Psychiatrist position was covered by other agency providers; the Nurse who left the team eventually decided to rejoin the team. Other positions that were vacant were filled within one or two months.	
H7	Psychiatrist on Team	1 – 5 4	The ACT team has one Psychiatrist who averages 33 hours of service weekly to 90 members (.92 FTE Psychiatrist). The ACT Psychiatrist's services are via telemed, although he is based in a neighboring suburban city in Maricopa County, and sees members on Monday, Tuesday, Thursday and Friday. The Psychiatrist does not attend any program meetings but attends the Wednesday staffing meeting by teleconference. Staff said that the Psychiatrist consults or provides some related service at a psychiatric hospital in Tempe, but that they do not think those duties interfere with his ACT responsibilities. Staff described the Psychiatrist as having good rapport with members, knowledgeable and providing an education and leadership role on the team as it pertains to psychiatric services. They say he is accessible by phone and email, including after business hours and on weekends. Staff said that for members who are unable or unwilling to come to the clinic to see him, the telemed service can be brought to where they are living or currently located. This is facilitated by one of the Nurses. Though most staff said that telemed services were working out positively for the team, some members interviewed expressed dissatisfaction with telemed, experiencing it as impersonal and not conducive to trust. One member noted, and several others agreed, conversations with the Psychiatrist by telemed are not private since one	• Consider options for providing full-time psychiatric coverage for a 100 member team. • Evaluate options to respond to needs and concerns of members who do not feel comfortable with provision of care via telemedicine.

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			of the Nurses is always in the room running the equipment. The record review showed that some members would prefer to see the Psychiatrist in person.	
H8	Nurse on Team	1 – 5 5	Two full-time Nurses share responsibility for the 90 member team - preparing medication sets and coordinating their dispersement, giving injections, providing medication observations and education, setting up and monitoring tele-med appointments with the Psychiatrist, offering health and wellness activities, and coordinating with pharmacies. While the Nurses see all of the members both in the office and the community, there is some minor delineation of job duties: Nurse1 coordinates partnership with primary care providers and specialists while Nurse2 takes on more of the psychiatric follow up tasks. Both Nurses work four, ten-hour days, and are accessible by phone and email. Both attend all program meetings on days they are working. The Nurses share on-call duties and rotate that responsibility weekly. Neither Nurse has other responsibilities outside the team.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has two SASs; both have graduate degrees in counseling and both are Licensed Associate Counselors (LAC). SAS1 has been in her current position for over a year and during that time has received numerous agency and RBHA trainings in substance abuse treatment, including co-occurring disorders treatment. Additionally, the SAS1 reports further experience and training in substance abuse treatment in her part-time employment as a therapist at an area psychiatric hospital. The SAS2 has been in the position for just over six months; previous to that she worked in a similar role at the agency's detoxification center providing individual and group counseling.	

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			She has completed agency and RHBA training in substance abuse and co-occurring treatment and has completed relevant trainings in crisis prevention and response. Both SASs receive twice monthly agency provided individual supervision and twice monthly group SAS supervision.	
H10	Vocational Specialist on Team	1 – 5 4	The ACT team has two vocational staff. It was reported by staff and members that they both help members find and keep jobs in integrated work settings. The Employment Specialist (ES) has been in the position for eight months. While the reviewers found no evidence of specific trainings in vocational/rehabilitation services or how to assist members in finding and retaining competitive employment, monthly clinical supervision appears to have been provided in the specialty area. The RS has been in the position for slightly over two years. The RS has completed numerous trainings in ACT, the co-occurring model, and Wellness Recovery Action Planning (WRAP). No evidence was found specific to training in rehabilitation/employment services, but the RS also receives monthly clinical supervision for employment services.	• Ensure that both vocational staff receive regular training in assisting people diagnosed with a serious mental illness (SMI)/co-occurring disorders, to find and retain employment in integrated settings.
H11	Program Size	1 – 5 5	The ACT team's 12 positions are fully staffed to provide sufficient coverage for up to 100 members.	
O1	Explicit Admission Criteria	1 – 5 4	The ACT team follows the RBHA's *ACT Admission Criteria Screening Tool*, which is based on SMI diagnosis, high utilization of crisis/emergency services including law enforcement, and poor responsiveness to standard services/inability to meet basic survival and independent living needs. Referrals come from a variety of sources: the RBHA, other clinics, hospitals, and internally from	• Ensure that all admissions comply with the explicit admission criteria.

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			the Crisis team. Additionally, CBI's PATH (Projects for Assistance in Transition from Homelessness team might refer a member seen at Central Arizona Shelter Services (CASS). Some referrals originally intended for Forensic or Medical ACT team may be diverted to the Avondale Act when the former teams have reached capacity. Screenings may be conducted by the CC or any of the specialists. Screenings are reviewed with the Psychiatrist, CC, and the rest of the team; final determination is based on the individual meeting the criteria and if questions remain are resolved by the ACT Clinical Lead, the Senior Director of Clinical Services, the Director of Clinical Services, and the Psychiatrist. The ACT team occasionally chose to accept members whose diagnosis does not fully conform to the model; in one case identified it was stated that the member, who was doing poorly in supportive care, probably should have been in developmental disability services, but ultimately has done well in ACT. In these cases, the decision was based on the assessment that ACT services could nonetheless benefit the individuals.	
O2	Intake Rate	1 – 5 5	Per data provided by the agency, the ACT team accepted eight members in the six months prior to the review: August (1), September (3), October (1), November (1), December (2), and January (0). The team does recruitment through face-to-face discussion with clinic and hospital staff; also the PATH team at CASS and the Crisis team may engage directly with clinic staff if it appears a member would benefit from the ACT level of care.	
O3	Full Responsibility for Treatment Services	1 – 5 5	Along with case management services, the ACT team is fully responsible for psychiatric services, substance abuse treatment,	• The ACT team should limit use of Access and Transition Points as temporary housing

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			counseling/psychotherapy, employment and rehabilitative services, and housing services. One member on the team continues to see the former ACT Psychiatrist who is now with another CBI ACT team. . The SASs both provide individual and group substance abuse counseling. Staff reported that referrals to more intensive day treatment programs are rare. In addition, the SASs are both credentialed to provide counseling/psychotherapy; one chart showed several episodes of an SAS providing couples therapy for a member and spouse. Staff said that vocational staff work directly with members on employment goals using a strengths-based approach that emphasizes work as a stage of change in recovery, from engaging members to develop a schedule of meaningful activities to guiding them in competitive job searches. Other than peer support certification programs, staff said that they do not refer to external employment service providers. Staff told the reviewers that the vocational staff are assisting approximately seven members to obtain employment; 13 members are currently working. It was reported that six (7%) members, including one in the 30-day rehab facility, live in staffed settings. Most records showed evidence that ACT provide housing support to members, including assistance with housing applications, searches, and lease signings. However, one record showed at a member had stayed at the agency's West Valley Transition Point for longer than two week	after hospital discharge while waiting for other living arrangements.

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			between a hospitalization and placement in a temporary living placement (TLP).	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team responds to crisis 24 hours a day, seven days week via on-call services that are shared by the specialists, rotating daily at 11AM. The on-call number is forwarded to each specialist's mobile phone so there is no need to hand off phones. On-call rotates daily; the CC is the back up on call. The on-call has 15 minutes to respond to incoming calls, and if unable to respond contacts the CC for back up. The on-call can respond on-site to crisis; staff are assigned CBI cars and can transport members if they need to be seen at the clinic or taken to the hospital. ACT staff report that they attempt to stabilize members in crisis in order to avoid unnecessary psychiatric hospitalizations. When attempts to stabilize are unsuccessful, they take the member to the agency's Access Point (AP) for a 24-hour triage, assessment and brief intervention, where they can be seen by the ACT Psychiatrist. If brief inpatient services are indicated, the ACT Psychiatrist can transfer the member to the agency's Transition Point for two – five days.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Although data provided to the reviewers indicated that the ACT team was directly involved in 100% of psychiatric hospital admissions, a review of the last ten admissions with the CC found that the team was involved with 70%. In three cases, members self-admitted, including one member who had been on outreach with the team. It appears in those cases, the ACT team was notified immediately by the hospitals and the team coordinated with hospital staff on discharge planning or any necessary transfers. The ACT team completed amendments to court ordered	• Continue to educate members and their informal supports on the benefits of involving the ACT team immediately when seeking psychiatric hospitalization. • The system should consider options for expanding *Care Reunify* or a similar system to psychiatric admissions.

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			treatment (COT) for five members. One member was petitioned for danger to self/danger to other (DTS/DTO) ideations. The team also coordinated with the county hospital to renew COT inpatient days while the member was on the wait list for Arizona State Hospital. The ACT team coordinated admissions with guardians, the Office for Human Rights, and/or public safety for several of those admissions. Staff reported that when members are admitted to any hospital for physical health emergencies, the new *Care Reunify* system (Aetna) alerts all staff immediately. Staff said that no such system is currently in place for psychiatric self-admits, but that they would welcome such.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per a review of the last ten psychiatric hospital discharges, the ACT team was directly involved in 100%. Staff said that discharge planning begins at the time of admission, at which point ACT staff begin making contact with the hospital Social Worker and inpatient medical staff. A doctor-to-doctor conversation is scheduled, and a staffing before discharge to ensure appropriateness. Guardians and Office of Human Rights (OHR) are invited to attend if they are involved with the member. The ACT team sets up housing arrangements if this is needed and provides transport to housing or wherever the member chooses to go, which may be to CASS. Per the record review and a review of psychiatric hospital discharges, some members are discharged to the agency's Transition Point. One record suggested that this occurred while waiting for a TLP. Staff assist members with picking up medications, scheduling needed PCP appointments, and making	

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			arrangements to see the ACT Psychiatrist with 24 hours. Staff conduct five-day face-to-face contacts with the member and document attempts to see those who are homeless when they have declined housing assistance.	
O7	Time-unlimited Services	1 – 5 4	According to staff interviewed, two members graduated from the ACT team in the past 12 months. Graduation is considered for members who have shown significant improvement as evidenced by decreased utilization of ACT services or crisis/emergency services. The ACT team uses the RBHA *ACT Exit Criteria Screening Tool* to assess appropriateness for stepdown to a lower level of care. According to ACT staff, they have been directed by the RBHA that graduation from services is the goal and appropriate when members have not needed the service intensity for at least 12 months. Some staff interviewed acknowledged that this directive may be inconsistent with the RBHA's exit criteria. Per interviews with members and staff, as well as the record review and program meeting observed, discussions about stepdown occur on a regular basis. Some members interviewed reported that staff had discussed stepdown with them; one member described ambivalence on the subject, while another rejected the idea completely. One record showed that though a member vigorously denied the suggestion that he was stable enough to stepdown, the staff's plan was to continue periodic discussions about stepdown to a lower level of care. For the next 12 months, the team expects to graduate 11% of membership, three in the next 30 days and seven during the remainder of the year.	• ACT teams in high fidelity rarely close cases but allow a flexible service intensity to respond to members with a documented pattern of functioning poorly in less intensive traditional case management. The system should maintain a focus on providing time-unlimited service with fewer than 5% annual graduation.

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S1	Community-based Services	1 – 5 4	Staff interviewed estimated that approximately 80% of their member contacts occur in the community. Members interviewed said that staff meet with them both in the community and in the office. Community contacts may be in the home but might also be in other locations such as during visits with a PCP or a parole officer (PO). Per the record review, 62% of face-to-face contacts with members occurred in the community.	• Continue efforts in increase member community contacts to 80% in order to promote, model and monitor skill building and independent access to resources and new community supports.
S2	No Drop-out Policy	1 – 5 4	The ACT team retained 92% of its membership in the last 12 months. Per a review of provided data, the ACT team identified two members who were closed because they could not be located in the last year or left the community without a referral. Five members could not be located using the outreach strategy and were placed on navigator status outside the agency. All members who cannot be located are put on eight-week outreach; if the team is unable to locate, they are moved to navigator status where outreach continues. One individual whose case was ultimately closed would only engage long enough to be released from jail and then would refuse or avoid contact, and currently has a warrant out for arrest. When staff learn that a member wants to leave the area, they assist the member in transitioning to new services. The team was able to successfully do this for a member who left the state for a job opportunity; another person left the state to live with a parent and received assistance from the team in transitioning to new services. Another member often spoke with staff of wanting to go to another state before suddenly relocating there without informing staff. The member later sent "selfies" to	• Evaluate trust and rapport building strategies with difficult to engage members; brainstorm meaningful ways to motivate engagement of members who may be reluctant to participate in services. • Continue efforts to involve informal supports as team partners in supporting members' recovery.

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			the team upon arrival, but because he declined to identify his location, staff were unable to assist him in connecting to services.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team uses an eight-week outreach strategy and checklist to locate and engage members who have been out of contact with the team; although, it reportedly often extends further by a couple of weeks. Outreach is tracked in program meetings using a system of rotating "blocks" of members who need to be located then assigned to each ACT specialist. During the program meeting observed, the CC prompted staff on planned action steps to make contact. Along with checking the member's home or preferred locations, staff contact jails, emergency rooms, the morgue, payees, and probation officers (PO). In the program meeting, staff reported on contacting informal supports as part of outreach. Staff said the *Care Reunify* system has been helpful locating members who were medically hospitalized. Additionally, staff now have a billing code they can use to track time spent outreaching members.	
S4	Intensity of Services	1 – 5 4	Per the review of ten member records, the median intensity of service per member was 87 minutes weekly. On the high end, one member received an average of nearly 243 minutes per week; on the low end another member only received 10 minutes. Five members received between 91 and 243 minutes per week.	• Continue efforts to increase intensity of services to an average of at least two hours weekly, with an emphasis on services in the community.
S5	Frequency of Contact	1 – 5 3	Per the record review of one month time frame, the median face-to-face contact was 2.5 per member, per week. Average contacts per week ranged from less than one to 3.75. Staff interviewed said members reside in a large catchment area and that the distance traveled	• Identify and resolve barriers to increasing contacts with members to average at least four and ensure all are documented. • Consider the feasibility of rotating zoned coverage as a solution to reducing travel time in the large catchment area.

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			poses a challenge to weekly contacts.	
S6	Work with Support System	1 – 5 2	Staff interviewed discussed their team goal to increase the involvement of informal support systems. Staff reported that approximately 40% of members have some level of informal support, usually family, and that the team has at least one weekly contact with someone from each of those members' support systems. Per the record review, the team documented one contact for each member. Although a number of informal support contacts were discussed in the program meeting and several members said the team had regular contact with family members, only two records showed any documented contacts with informal supports. Some records did show that staff made efforts to assist members in building an informal support network through referrals to peer run programs and faith-based organizations.	• The ACT team should continue periodically reviewing with members the benefits of engaging informal supports, and including them in treatment. Help members identify current informal supports and build new ones; sources of support can often be found within communities with shared interests, values and priorities such as . faith based organizations, hobbies and leisure interests, and volunteer groups. • Ensure informal contacts are documented in the member record in a timely manner and adequately reflect the nature of the contact.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Per staff report, between 52 – 55 of the 69 members with a co-occurring disorder receive individual substance abuse treatment each week. Staff said sessions average 30 minutes each. Per agency provided encounter reports for the two SAS's, 47 members (59%) received an average of two, 30-minute individual substance abuse treatment sessions in the month reported; some received up to four. Completed individual sessions were not evenly dispersed between the two SASs. The SASs provided less than 24 minutes of substance abuse counseling across all members with a co-occurring disorder. Formal, structured individual substance abuse counseling was evidenced in numerous records reviewed. Sessions appeared to be organized around each member's stage of change. One SAS	• Consider any barriers to SASs carrying out their specialty so that members with a co-occurring disorder receive an average of at least 24 minutes of weekly individual formal substance abuse treatment. • The CC and SASs should continue to mentor specialists to engage members in discussions about substance use and formal substance abuse treatment that could support their immediate priorities and long-term recovery goals.

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			tended to use repetitive, nonspecific verbiage across records when referring to interventions used, while the other SAS identified interventions referencing stage-wise treatment approaches (i.e.: specific harm reduction strategies, cognitive restructuring techniques, *weighing pros and cons, values clarification, identifying discrepancies*, etc). Other documentation showed that staff other than SASs provided peer support around substance use, including use of self-disclosure to encourage engagement in active co-occurring treatment.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SASs offer two co-occurring disorder treatment groups weekly. The SAS1 facilitates a group on Tuesday that focuses on action and maintenance stages of recovery, while the SAS2 offers a group geared toward pre-contemplative through preparation recovery stages on Friday. Staff reported the SASs use the RBHA developed substance abuse treatment curriculum, as well as supplemental materials from the agency's shared drive such as *Seeking Safety* and relapse prevention. Staff said that the curriculum and other materials draw from an integrated dual diagnosis treatment model. Both groups last an hour. Sign-in sheets for a one month timeframe showed that 19 members (28%) attended at least one group. Staff also reported that the CC provides a weekly wellness group that often includes psychoeducation about the effects of substance use on health and wellness, as well as interactions with psychiatric medications.	• ACT team should identify members who have not engaged in substance abuse treatment groups and strategize to increase participation to at least 50% of members with a co-occurring disorder. • If readiness is a factor in lower participation, staff should brainstorm to identify what these members are ready for, and any group curricula could address their priorities while moving them forward to the next change stage.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Both SAS staff demonstrated knowledge and experience applying stage wise treatment approaches that align with stage of change. Specific examples such as developing discrepancies, values clarification, and weighing	• Ensure that all specialists receive regular training and clinical oversight in the co-occurring model, including harm reduction techniques and the stage-wise treatment

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			pros and cons were evidenced in the program meeting, documentation, and interview, although one SAS may have difficulty effectively translating interventions used into written documentation. The ACT team primarily operates according to the co-occurring model. One staff interviewed stated several on the team had been unfamiliar with harm reduction tactics, having been previously trained in traditional abstinence based approaches. However, staff reconfirmed that all staff have been trained in the co-occurring model and described the team as embracing anything they can do to increase safety for members whether they use or not, be it through housing, employment, or a new support system. For example, another staff gave the example of helping members identify safe places to get intoxicated or safe people to get high with. Though it was reported that all staff regularly address substance use with members, one staff training transcript examined did not show any documentation of co-occurring trainings. One record reviewed documented that staff used traditional approaches that emphasized powerlessness in response to the member's heavy use of substances. Other staff said that while the team does not use or promote 12-step treatment, some members request assistance in finding community meetings, and this is provided. One staff said that the team was able to obtain an ROI for one member's 12-step sponsor (who was identified as an informal support).	approach. Staff unfamiliar with these strategies may benefit from mentoring in the community with the CC or other highly skilled staff.
S10	Role of Consumers on Treatment Team	1 – 5	The ACT team has an assigned PSS who is considered integral to the team and shares equal	

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		5	responsibilities with the other specialists. The agency values lived experience of recovery among direct service staff. Most staff interviewed readily discussed the role of their own recovery journey in shaping their professional identity and helping them build trust and rapport with individuals used to stigma and rejection. Members interviewed similarly described the value they place in being able to process their struggles with people who have walked in their shoes and overcome similar obstacles.	
Total Score:		**4.21**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
3. Program Meeting	1-5	4
4. Practicing ACT Leader	1-5	4
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	4
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	5
4. Responsibility for Crisis Services	1-5	5
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	4
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**118/28=4.21**	
Highest Possible Score	**5**	