ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 31, 2018

To: Amy Henning, Chief Executive Officer
Crystal Domblisky-Klein, Director of ACT Services

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AHCCCS Fidelity Reviewers

Method

On January 9 – 10, 2018, Karen Voyer-Caravona and Thomas Eggsware completed a review of the Southwest Network Royal Palms 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 (SWN) is contracted to provide behavioral health care to members diagnosed with a Serious Mental Illness (SMI) in Maricopa County. The Royal Palms ACT team, previously reviewed as the Bethany Village ACT, relocated in the last year to a newly renovated site at 2311 West Royal Palms Road in North Phoenix. The clinic is accessible by public transportation, including a new light rail station, and is in close proximity to local businesses. In addition to the new location, several new staff joined the team in the last three months, including most recently the Team Leader/Clinical Coordinator (CC), the Housing Specialist (HS), and the Peer Support Specialist (PSS). The ACT team served 93 members at the time of the review, 56 of whom are diagnosed with a co-occurring disorder. The team has historically served the SMI young adult population, and though no longer a young adult program, the team still serves significant numbers of young adult members.

The individuals served through the agency are referred to as "clients" and "members", 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 January 9, 2018;
- Individual interview with the CC;
- Individual interviews with Substance Abuse Specialist (SAS), (PSS), and Rehabilitation Specialist (RS);
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- A review of agency provided documents including: resumes and training transcripts for the SAS, RS, and Employment Specialist (ES); CC encounter report; Regional Behavioral Health Authority (RBHA) developed *ACT Admission Screening Tool* and *ACT EXIT Criteria Screening*

Tool; SWN *Lack of Contact Checklist*; Substance Abuse Group sign-in sheets; and SWN *Inpatient Discharge Planning Adult Policy and Procedure statement*.

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:

- Team approach: Per ten randomly selected member records, 100% of members had contact with more than one ACT staff member in two weeks. The CC assigned members for each staff to see weekly; coverage is monitored daily in the program meeting to identify which members still need to be seen.
- Program size: At the time of the review the ACT team was fully staffed for necessary diversity and coverage. The 12 member team was comprised of the ACT CC, the ACT Psychiatrist, two ACT Nurses, two SASs, an ES, an RS, a HS, an ACT Specialist, a PSS, and an Independent Living Specialist (ILS).
- Low intake rate: For the six months prior to the review (July – December 2017), the ACT team admitted four members. The highest number of intakes (2) occurred in August.
- No drop-out policy: The ACT team had a 96% retention rate for the past 12 months. The ACT team uses a six-week ACT Lack of Contact Checklist with prompts for street outreach and outreach to informal and other supports to assist them in finding members who are difficult to locate.
- Role of Peer Support Specialist on the team: PSS functions as an equal member of the clinical team with the same level of responsibilities and expectations. The PSS is highly motivated to use his lived experience to facilitate new member engagement, as well as engagement of informal supports, to help members in attaining recovery goals that they identified as personally meaningful for their service plans.

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

- Practicing ACT leader: Per encounter reports provided by the agency and a review of member records, reviewers found limited evidence that the CC provides direct member services. However, the recently hired CC spent considerable time in required training. The CC should provide direct member services at least 50% of the time; these may include services conducted as part of mentoring and shadowing specialists in implementing interventions, especially those provided in the community.
- Continuity of staff: The ACT team experienced 50% staff turnover in the last 24 months. High staff turnover is found to be a barrier to building and maintaining the rapport and trust necessary for an effective therapeutic relationship; high turnover may also reduce the benefits of agency investments in staff training and education. Focus on retaining staff, with no more than 20% turnover in a two year

period.

- Full responsibility for treatment services: In addition to case management services, the ACT team is responsible for psychiatric services, substance abuse treatment, and most housing services. With close to 10% of members in staffed or semi-staffed housing, the ACT team should work with members currently residing in staff/semi-staffed setting to find independent housing in integrated settings whenever possible. The ACT team does not provide general counseling/psychotherapy and should consider options for providing this service. The team should also be actively providing direct assistance with members to obtain and retain employment in integrated settings.
- Co-occurring treatment groups: The ACT team should increase participation by dually diagnosed members in co-occurring treatment groups from 18% to at least 50%. Consider developing co-occurring groups that are culturally relevant to the needs of specific subgroups of the ACT team. For example, Spanish speaking members may be more receptive to engagement presented in Spanish, while young adult membership may welcome a format sensitive to their experiences.
- Co-occurring model: It appears that the ACT team combines principles of the co-occurring model with more traditional approaches that emphasize abstinence and confrontation. The RBHA and the agency should continue to provide training and education in the co-occurring model, to develop skills in non-confrontational and stage-wise treatment approaches, such as motivational interviewing, harm reduction, practical skills training in goal-setting and self-efficacy, cognitive behavioral strategies, crisis intervention and relapse prevention. Staff who provide clinical oversight should consider periodically reviewing progress notes to ensure language properly reflects co-occurring services.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	Staff interviewed said that they share responsibilities for all 93 members, and that caseloads are for the purposes of paperwork requirements only. Excluding the ACT Psychiatrist, the member to staff ratio is approximately 8:1.	
H2	Team Approach	1 – 5 5	Per a review of ten randomly selected member records, 100% of members had contact with more than one ACT staff in the two week period identified for review. Staff interviewed said that the CC assigns each specialist a schedule of members to be seen; coverage is discussed at daily team meetings, as well as who has not been seen. One staff noted that many members are seen in various weekly groups scheduled in the community.	
H3	Program Meeting	1 – 5 5	The ACT team conducts team meetings four days a week on Monday, Tuesday, Thursday, and Friday. The group begins at 10AM and lasts approximately one hour. Staff reported that all members are discussed. At the meeting observed by the reviewers, most staff were present, although one Nurse and the ACT Psychiatrist arrived late due to being with members. The meeting was led by the CC, who prompted for updates on contact, status, and type of engagement, and gave direction where appropriate.	
H4	Practicing ACT Leader	1 – 5 3	The CC had been with the team for a little over a month at the time of the review. The CC reported that he thinks he spends about 50% of his time providing direct member services both in the office and the community, doing activities similar to what every specialist on the team provides	• Increase the CC's time spent providing face-to-face member services to 50%. This may occur in the context of community-based mentoring and shadowing of specialists during such activities as home visits, crisis response, housing searches and lease

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			(such as encouraging daily living skills, socialization, assisting with housing applications, coordinating discharges, and working with them on service plans). Per real-time encounter data provided by the agency for a month timeframe, the CC spent approximately 11% of his time providing direct member care. The reviewers found two progress notes from the CC in the ten member records reviewed. However, it was reported that over that time the CC spent about 20 hours in training.	signings, hospital staffings, and support provided at mental health court. • Consistently document face-to-face contacts with members in the agency's documentation system. • Identify administrative tasks currently performed by the CC that could be assumed by the Program Assistant in order to free up more time for direct service.
H5	Continuity of Staffing	1 – 5 3	The ACT team experienced a staff turnover rate of 50% in the last 24 months. Six new staff joined the team in the last 12 months; three staff, including the CC and two others, joined in the month prior to the review. Additionally, the Psychiatrist role had been covered by four different providers before being filled by the current Psychiatrist.	• Identify factors that may have contributed to recent staff turnover, or have supported retention, and seek to implement solutions. • Anonymous surveys and exit interviews may provide insights; investigate effective solutions found by teams that have reached high fidelity in this area.
H6	Staff Capacity	1 – 5 4	The ACT team had a total of 19 vacancies for the 12 months prior to the review. Also counted among vacancies was one specialist who was on maternity leave for more than a month prior to the review. That specialist is scheduled to return to work at the end of the month. Calculating for all vacancies, the ACT team operated at 87% capacity for the year.	• See recommendations for Item H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a full-time Psychiatrist. Staff interviewed said that the Psychiatrist is with the team on Tuesdays – Fridays, for 40 hours each week, and attends team meetings on Tuesday, Thursday and Friday. Staff said that the Psychiatrist sees ACT members in the community on Wednesdays, and is accessible by phone, text or email including after hours and on weekends. One staff said that the Psychiatrist covers a	

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			supportive team on Mondays but this does not appear to distract from his ACT responsibilities. Staff interviewed were not aware of any other responsibilities outside of the ACT team for the Psychiatrist. Members and staff interviewed reported being pleased with the Psychiatrist's services.	
H8	Nurse on Team	1 – 5 5	The ACT team has two full time Nurses. One Nurse works four, ten hour days, while the other works a five-day schedule. Both share equal responsibility for office and community-based delivery of nursing care including providing injections, *medisets*, medication and wellness education, coordination of care of primary care providers (PCP), and accompanying members to outside medical appointments when requested. Staff said the Nurses attend team meetings, and are accessible by phone, email, and text, including after hours and weekends.	
H9	Substance Abuse Specialist on Team	1 – 5 5	Two full-time SASs serve the ACT team. SAS1 has been with the ACT team for about 1.5 years, is a Licensed Master of Social Work with graduate level course work in dual diagnosis/co-morbidity and has previous internship placements working with the homeless population at the City of Phoenix Homeless Department and with the Phoenix Vet Center. She reported currently receiving outside training toward certification in Eye Movement Desensitization and Reprocessing (EMDR) Therapy. As a previous ACT Specialist, she provided Cognitive Behavioral Therapy and Dialectical Behavioral Therapy. The SAS2 has been with the team for approximately 14 months. Per resume, the SAS2 served in the same role on another ACT team since 2009, has an Associate's degree in Human Services, and has been in	

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			addictions recovery for over 21 years. Per staff interview, the SASs both receive one hour of supervision monthly from the Clinical Director, and also have completed agency and RBHA training in ACT substance abuse treatment, motivational interviewing, and American Society of Addictions Medicine (ASAM) criteria.	
H10	Vocational Specialist on Team	1 – 5 5	The ACT team has two vocational staff on the team. The ES has been on the team for over two years and has previous work experiences in benefits counseling and providing job development support to college students and homeless women. The RS has been with the team in that role for over two years. Both the ES and the RS have completed agency and RBHA trainings in vocational services, including assisting members in obtaining employment. Per interview, they attend quarterly in-person RBHA training in employment but it was not clear how consistently these are attended or what topics are covered.	• Ensure both vocational staff receives ongoing training in helping members find and retain employment in integrated settings.
H11	Program Size	1 – 5 5	The ACT team is of sufficient size and diversity of specialty staff to provide necessary coverage and range of services to the 100 members. At the time of the review, all positions were filled.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team uses the RBHA developed *ACT Admission Screening Tool*; a copy was given to the reviewers. Potential candidates for ACT services were described by staff as high utilizers of psychiatric hospitals and crisis services, who have difficulty with daily living skills, and need more intensive support in personal hygiene, budgeting, self-advocacy, and housing services. Referral sources include the clinic, other provider agencies, and the RBHA, although they may also originate from hospitals and correction facilities. At the	

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			time of the review, the CC and the SAS1 conduct the screenings, which are then staffed with the ACT Psychiatrist, and then the referral is discussed with the entire team.	
O2	Intake Rate	1 – 5 5	In the six months prior to the review, between July and December 2017, the ACT team admitted four members to the team. Two members were admitted in August and one each was admitted in October and November. Though some screening had occurred in December, the CC was still waiting for additional required documentation before the team could proceed with other program admissions. The CC reported no external pressure to admit members who do not fit the ACT admission criteria.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management services, the ACT team directly provides psychiatric services, substance abuse treatment, and most housing support. No members were identified as receiving outside assistance in either psychiatric services or substance abuse treatment, and less than 10% of members live in residences where they receive some level of non-ACT staff support. Though no members are currently receiving general counseling/psychotherapy, staff interviewed reported that no ACT staff are designated to provide this service, so it would be referred out. With regard to employment services, staff interviewed said the team provides assistance with resumes and job development activities, but that they were not currently assisting any members with employment goals. One member receives assistance through the Marc Center. The record review showed evidence that in groups, staff talk to members about how VR can	• Explore solutions for providing general counseling psychotherapy on the ACT team; in future hiring decisions, consider candidates' qualifications to provide this service. • As with other services, ACT teams, beginning with the vocational staff, should assist members in finding and retaining employment in integrated settings.

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			help with employment, but do not discuss what assistance the team can provide toward finding and retaining competitive work.	
O4	Responsibility for Crisis Services	1 – 5 3	Staff reported that the team has 24 hour on-call services for members in crisis. On-call is rotated between staff members from Wednesday to Wednesday and the CC is always the back up; additionally, the SAS1 and the AS work Saturday and Sunday, respectively. Staff said the crisis line will notify the team if they get the initial crisis call and that the team will respond to the member in crisis at that point. Staff said they do not have a written on-call information sheet, but instead rely on providing face-to-face information to members regarding how to access the team for crisis situations. However, the reviewers saw evidence in one record that the team lacks a well-planned strategy to address the potential for simultaneous crises on an ACT team. Documentation showed delays in responding on-site to a member in crisis when more than one designated on-call staff were unable to respond to a member who was endorsing "danger-to-self". The team initially sought to dispatch a mobile team through the crisis system, who was unable to respond due to having no phone number for the member, so on-call staff eventually made contact with the member in the community. Another record indicated that some staff may take a punitive approach to crisis calls; one staff member told the crisis line she would not collect a member from the hospital when he arrived intoxicated and had not been admitted.	• Provide members with written, on-call information and instructions on how to access the ACT team during crisis, and ensure the team understands a plan for coverage and responsiveness to support individualized treatment goals.
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff interviewed said that when members present as a danger to themselves and/or others, or experiencing increasingly bothersome symptoms	• Continue to educate members and their informal supports on the benefits of

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			such as auditory hallucinations, staff will triage the case with one of the Nurses and have the Psychiatrist see the members. If hospitalization is deemed appropriate, staff will take the member to the closest emergency room and facilitate the admission, remaining with the member until they are admitted. During after-hours situations, on-call staff will talk to the member and try to stabilize them until they can pick them up on-site. The CC often recommends that the Psychiatrist or Nurses also be notified. If it is deemed unsuitable for the member to be transported, such as when exhibiting danger to others, public safety is requested to transport. Per a review of the last ten psychiatrist hospital admissions with the CC, the ACT team was involved in 70% of admissions. Staff reported three cases in which members self-admitted, when they were trying to solve underlying problems such as chronic homelessness and substance abuse. Staff said the team tries to provide education and services to address these core issues (i.e., housing applications, detox if appropriate) with members who frequently self-admit.	contacting ACT staff during crisis and when considering the need for psychiatric hospitalization; a written protocol and contact list, provided to members and their supports, on how to access the ACT team to assist with crisis and psychiatric evaluation for hospitalization, may lead to improvements for this item.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff described discharged planning beginning at the time of hospital admission with staff making contact with the hospital Social Worker, arranging doctor-to-doctor calls or meetings, determining housing plans, etc. Doctor-to-doctors usually happen within 24 hours of admissions; ACT staff meet with the member within 24 hours of admissions and every 48 – 72 hours thereafter until discharge. At the time of discharge, staff go to the hospital to collect the member, along with hospital paperwork, assists the member in filling prescriptions at the pharmacy, and takes the	• The RBHA, agency, and the ACT team should seek to collaborate to resolve any breakdowns in communication that result in psychiatric hospitals discharging members without previously notifying the ACT team. • ACT staff should be responsible for discharge planning with hospital Social Workers, inpatient Nurses, and other inpatient staff. Evaluate how effectively the clinic DCP supports fidelity to this item.

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			member to wherever they are to be housed. Members are then to see the ACT Psychiatrist within 24 hours, excluding weekends, the Nurse within 72 hours, and have five days of face-to-face contact with staff. A review of the last ten psychiatric hospital discharges with the CC showed the ACT team was directly involved in most discharges. In one case, the member refused to meet with or speak to ACT staff while hospitalized; in one case the member refused to wait for the staff and left on her own; in another case, a guardian discharged the member and took him to his housing. Per the review of member records, some discharges were dated subsequent to the data provided and also showed that some hospitals discharge members without notifying the ACT team. Two records examined also showed that the clinic Discharge Planner (DCP) rather than ACT staff appeared to be doing the majority of discharge planning, including arranging staffings at the hospital and housing plans.	
O7	Time-unlimited Services	1 – 5 4	Staff interviewed said that graduations or step-downs from the team to a lower level of care are initiated upon member request. Although staff did not outline a specific strategy to manage step-downs, they said that members who would be considered appropriate for discharge would be those who have been without psychiatric hospitalization or crisis services for over a year, have a stable living situation, are medically compliant, and perhaps working. The ACT team uses the RBHA *ACT EXIT Screening Tool* to assess member appropriateness for graduation. Staff said members can chose to transition gradually or transfer when a receiving team is ready for their admission. Data provided showed that two	• Because members often regress when transferred to lower levels of care that cannot respond to crisis with similar immediate service intensity, ACT services are meant to be time unlimited. Consider a gradual step-down protocol over 60 – 90 days for members expressing an interest in graduation from the team.

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			members graduated with significant improvement in the last 12 months. The CC anticipated that five members, including one that is in the process of moving to a supportive team, may be graduating in the next year.	
S1	Community-based Services	1 – 5 4	Staff interviewed estimated that 80% of the member contacts occur in the community. Members interviewed reported seeing staff both in the clinic and at their homes. Per a review of ten member records, face-to-face contacts occurred in the community 68% of the time. Those contacts occurred in a variety of settings including home, hospitals, mental health court and recreational settings. Staff reported that several skill-building groups occurred in the community. Two groups, a co-occurring treatment group and a health and wellness group, meet back-to-back weekly at a bowling alley, while two other groups meet back-to-back at another community location.	• Continue efforts to increase community-based service delivery to 80% with emphasis on individualized, person-centered services that align with member service plan goals, needs, and objectives.
S2	No Drop-out Policy	1 – 5 5	Per interview and data provided, no members were closed because the team determined they could not be served, refused services or left the geographic area with a referral. Three members relocated out-of-state without referrals. The CC said that these instances occurred prior to his employment and he had no background information on those situations. A fourth member has been placed on Navigator status with the agency, after the team was unsuccessful at outreach, but not closed with the agency and can return immediately to the team upon being located. Another member's case was closed after he was arrested while visiting California, and subsequently sentenced to an extended incarceration period.	

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S3	Assertive Engagement Mechanisms	1 – 5 5	Staff provided the reviewers with a copy of the agency *Lack of Contact Checklist*, which indicates that outreach occurs over a minimum of six weeks and includes letters of intent to transition to a lower level of care and a letter to close and Notice of Action. Staff said that two staff rotate outreach duties weekly. Outreach is discussed daily at the team meeting to determine what has been done and next steps; this was observed by the reviewers. Staff described using various outreach strategies to keep members engaged in the team. Outreach occurs over phone, calling the member, but also hospitals, morgues, and jails, as well as contacts with informal supports, such as: payees, parole officers, advocates, and guardians. Outreach also includes community-based street outreach mechanisms, such as going to favorite places where the member might be expected to be located (i.e., home, bus stops or convenience stores, shelters, parks, or street corners). Staff described finding one missing member at the home of a former girl-friend after staff located her address in the member electronic record.	
S4	Intensity of Services	1 – 5 4	Per a review of ten member records, members receive an average of 99 minutes of face-to-face services with ACT staff per week. Some staff reported that a significant amount of service time can be accounted for through group treatment. Of the ten records sampled, it appears that 46% of service time was delivered in groups. One record showed that 92% of service time delivered was in groups. Reviewers noted four groups were provided, and located in the community. Two back-to-back groups delivered on Thursdays typically last over 90 minutes each, covering multiple topics ranging from healthy eating,	• Continue efforts to provide an average of two hours of service time per week to all members across the team. • Ensure that contacts derived from groups align with individualized goals in member service plans.

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			budgeting, establishing healthy boundaries and relationships, and coping skills, all within a single group. It was not clear to the reviewers how such wide-ranging content could be covered and discussed in a meaningful way. Documentation also indicated that content was replicated from one group to the other, and week to week.	
S5	Frequency of Contact	1 – 5 4	Per the record review, members received an average of 3.13 face-to-face contacts with ACT staff per week. As described in item S4, many contacts occurred in the context of back-to-back groups. Of 140 contacts counted in ten member records, 21% occurred in group activities.	• Continue efforts to provide an average of four contacts per week to members across the team. • See recommendation in S4, Intensity of Services.
S6	Work with Support System	1 – 5 3	Staff reported that 80% of members have some type of informal support system, usually a family member. Staff said that because the team has many young adults, family supports are often parents who sometimes are also legal guardians. ACT staff reported having weekly contact with the informal support system of most members who have them, if there is a signed Release of Information (ROI). The record review showed that on average, the ACT team has 1.40 contacts per month with informal supports.	• Continue engagement efforts with informal supports as partners in member recovery. • Periodically review with members the benefits of allowing the ACT team to initiate contact with informal supports, and obtain signed ROIs whenever possible. • Document all contacts with informal supports; staff may receive and document information from informal supports without an ROI.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Fifty-six members on the ACT team are diagnosed with a Co-occurring Disorder (COD). Staff reported that both SASs provide services to COD diagnosed members at any change stage; however, the SAS1 sees mainly members in the early stages of recovery, and the SAS2 sees members in the latter stages. Although both SASs provide individual substance abuse treatment, staff reported that the SAS2 was taking time off due to illness, only data for the SAS1 was available to the reviewers. The SAS1 has a caseload of 26 members with a COD; it	• Ensure that documentation for all formal individual substance abuse sessions is noted in the member record in a timely manner and with the type of service clearly identified.

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			was reported that the SAS1 sees all of them weekly for approximately 20 – 30 minutes. A calendar for the week of January 7 – 13, 2018 shows about 19 scheduled individual substance abuse counseling appointments. The record review confirmed several instances of regularly scheduled individual substance abuse counseling by the SAS1. Reviewers did not find in the records reviewed any instances of individual substance abuse treatment scheduled for the SAS2.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	ACT staff reported that the team provides two COD groups weekly. The SAS1 offers a group that is geared toward members in the earlier stages of recovery, pre-contemplative through preparation stages. This group takes place in the community, in an area outside of a bowling alley. Evidence of SAS1 group notes was found in several member records. The SAS2 conducts a weekly group geared toward latter stages of treatment, action stage through maintenance. Reviewers found an SAS2 group note in one member record. Both groups are about 60 minutes, and are open to members at any stage, as well as members who have addictions to other substances such as caffeine and nicotine. Staff reported that the SASs follow a 35-session co-occurring curriculum, Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual (DiClemente et al). Staff said that since recovery does not necessarily follow a linear path, group content may move back or forward to adjust for the group's changing needs. Reviewers noted that while some progress notes showed specialists encouraging members to attend COD treatment groups, some staff encouraged members to attend 12-step recovery groups.	• Continue efforts to outreach and engage at least 50% of members identified with a COD in at least one COD group each month. • Consider developing COD groups that specifically appeal to COD identified members who do not regularly attend COD groups but may derive benefit. For example, groups that target Spanish language, LGBT members, or young adults (or any subgroup the ACT team identifies as potentially benefitting) may increase the numbers of members receiving group treatment.

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			The reviewers were provided with sign-in sheets for the SAS1 substance abuse groups between December 6, 2017 and January 3, 2018. Eleven members (20%) attended at least one group during that period, with an average of six attending each session. Although, other members attended the co-occurring group, they were not identified in data provided as having a co-occurring disorder. The reviewers did not receive any data for groups provided by the SAS2.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	At the time of the review, it appeared that the ACT team approached substance abuse treatment with a mix of co-occurring disorders and traditional 12-step approaches. The SAS1 verbalized strong knowledge and embracement of the COD model, and her group progress notes show evidence of stage-wise interventions (i.e.: motivational techniques, harm reduction, exploring pros and cons, developing discrepancies, tipping the balance of change), and referring members to ACT COD groups. Additionally, staff interviewed easily described the harm reduction philosophy and see it as a more realistic option for many individuals identified with a COD. However, the reviewers also found repeated instances of staff questioning members' substance use, emphasizing abstinence, and encouraging members to follow up with 12-step groups documented by of some staff. Some progress notes also showed shaming and punitive responses to intoxication and substance use, which may have resulted in missed opportunities to explore the negative impacts of use and problem solving to reduce those impacts.	• Continue to train and support all ACT specialists in the co-occurring approach. The SASs should regularly provide cross-training and model and encourage stage-appropriate language as a more appropriate alternative to confrontational and punitive interventions. • The CC and/or other agency staff providing clinical oversight should periodically review progress notes to ensure language properly reflects co-occurring services.
S10	Role of Consumers on Treatment Team	1 – 5	The Peer Support Specialist (PSS) functions as an equal member of the team, with the same level of	

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		5	responsibility and duties as the other specialists. Staff said that the PSS in essential in building team rapport with members and their informal support network. Reviewers found several examples in the records reviewed of peer support provided to members including at hospitals and home visits. Though new to the team and the role, the PSS participated actively in discussion during the program meeting observed by the reviewers, sometimes initiating feedback and offering suggestions.	
Total Score:		**4.25**		

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

6. Responsibility for Hospital Discharge Planning	1-5	4
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	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	3
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	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.25**	
Highest Possible Score	**5**	