ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 5, 2016

To: Jennifer Nye, Senior Director of Recovery Clinics

From: Georgia Harris, MAEd
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ADHS Fidelity Reviewers

Method

On Tuesday and Wednesday, January 5 – 6, 2016, Georgia Harris and Karen Voyer-Caravona completed a review of the Terros Townley 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 Terros Townley Center Clinic is located at 8836 North 23rd Avenue in Northwest Phoenix. The ACT team was last reviewed in March 2015 when the clinic was under the ownership of CHOICES Network of Arizona. Terros assumed ownership of the clinic and several other CHOICES offices in mid-2015. The agency, founded in 1969 to respond to the behavioral health and treatment needs of people seeking to recover from substance abuse and addictions, is known for its expertise in mental illness and co-occurring disorders and has expanded their scope of services to include the integration of behavioral health and primary medical care. The individuals served through the agency are referred to as "clients" or "members", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

The Townley ACT team consists of twelve staff members: a Clinical Coordinator/Team Leader (CC), a Psychiatrist, two Nurses, two Substance Abuse Specialists (SAS), a Housing Specialist (HS), a Rehabilitation Specialist (RS), an Employment Specialist (ES), a Peer Support Specialist (PSS), and an ACT Specialist (AS). The CC stated that an Independent Living Specialist (ILS) was scheduled to begin employment the week after the review. The team served 93 members at the time of the review; 49 members are diagnosed with a co-occurring disorder (COD). While transitions can be stressful and disruptive for both staff and clients, the ACT team benefits from the leadership of an experienced ACT CC, who during the review demonstrated a thorough understanding of the SAMHSA ACT fidelity protocol. The ACT staff also praised Terros for providing substantive trainings in the ACT model and areas of specialization, namely substance abuse.

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

- Observation of a daily ACT team meeting;
- Individual interview with CC;
- Group interview with two SASs;

- Group interview with the RS, ES, and PSS;
- Group interview with five members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Review of the following agency documents: Eight Week Outreach Strategy, Mercy Maricopa Integrated Care (MMIC) ACT Admission Screening Criteria, ACT Morning Meeting Roster, and ACT Team Staff Contact List.

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:

- Consumer role on team: In addition to having a PSS who shares equal status and responsibilities of other ACT staff, the ACT team benefits from an SAS who self-identifies as a person with the lived experience of an SMI and/or a co-occurring disorder.
- Substance Abuse Specialists on the team: The ACT team has two trained and experienced SASs. One has over 20 years' experience working in substance abuse treatment, and is able to provide cross-training in the co-occurring disorders model to staff in other areas of specialization. The other SAS uses her own lived experience to engage and connect with members working through the stages of recovery, and has previously served as the team's PSS.
- Vocational Specialists on the team: The ACT team has both an ES and a RS. Each has training and/or previous experience assisting individuals who are diagnosed with an SMI and/or a co-occurring disorder identify, pursue and achieve employment goals. The agency and the Regional Behavioral Health Authority (RBHA) should continue efforts to provide them both with on-going trainings and resources to support them in providing 90% of vocational services on the team.

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

- Continuity of staffing: The ACT team has experienced a 77% staff turnover in the last two years. Some positions, such as the CC, the ES, the ILS and the PSS, have become vacant more than twice in that time period. The agency should make efforts to identify and respond to factors contributing to high staff turnover in order to support the therapeutic member/staff relationship, which research has repeatedly shown to be the most critical factor in member satisfaction, as well as staff cohesion.
- Community-based services: The ACT team coordinator should carefully monitor the outcome of the recently implemented staff schedule and provide appropriate supervision and mentoring to ensure that member contacts occur in the community at least 80% of the time. The CC may wish to consider combining the new scheduling rotation with zoned coverage, which some ACT teams have found helpful in increasing the frequency and intensity of member contacts in the community. The agency should consider what, if any, accommodations can be made to the staff work environment (i.e. technology) to allow them to decrease their presence in the office,

particularly for administrative tasks. Individualized SA treatment: Terros should consider options for allowing the two experienced Substance Abuse Specialists to provide individualized substance abuse treatment within the team, including opportunities to receive any necessary training and credentialing, or clinical oversight. If Terros chooses to continue using agency therapists from outside the ACT team to provide individual substance abuse treatment, those clinicians should coordinate with the CC to create a regular schedule for attending the daily morning meeting to provide updates on their member caseloads.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, the ACT team consisted of 11 staff (excluding the team Psychiatrist) serving 93 members for a staff to member ratio of 1:8.	
H2	Team Approach	1 – 5 5	A review of ten electronic member records found that for the period under review, 90% of members saw more than one staff member in two weeks. Staff said that the CC has very recently implemented a new coverage system. Caseloads or members lists change every month. On Mondays, staff see their full caseload, on Tuesdays they see another staff's caseload. The caseload to be seen changes each day. Staff said that they also see people based on area of specialization. Some staff interviewed prefer zone coverage, which they said reduces time wasted in traffic traveling across the county.	
H3	Program Meeting	1 – 5 5	Staff said that morning meetings are held four days a week, occurring Monday, Wednesday, Thursday and Friday, with Tuesday off for the Psychiatrist's flex day. The reviewers observed a morning meeting on Wednesday, January 6, 2016, from 10 – 11:30 a.m. The team reviewed the entire member roster. Most staff were in attendance, including the ACT Psychiatrist who took an active role in discussion.	
H4	Practicing ACT Leader	1 – 5 2	Although she could not provide a productivity report, the CC estimated that she spends 70% of her time in face-to-face contact. The CC said that she usually provides direct service in the community, sometimes by herself but also with	• CCs on ACT teams that achieve high fidelity in this area spend at least 50% of their time in direct member services, including mentoring and live supervision of ACT staff. • The ACT team and the agency should

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			the Psychiatrist. During the morning meeting, the reviewers counted eleven instances in which the CC reported on direct contacts with members. The record review, however, did not reflect this level of direct service by the CC, perhaps due to lack of documentation in the record. At the time of the review, the CC did not have a Program Assistance (PA) whose role is to support the administrative duties of the CC; currently temps fill that position. For example, the CC (instead of a full-time PA) creates and updates the staff email group lists and assembles provider referral packets. Out of 48 staff contacts (in ten member records) counted for the period under review, the reviewers found four face-to-face member encounters with the CC totaling 23.5 minutes, or less than 1% of the CC's service time. The results of the multiple data sources are reflected in the score for this item.	explore if any administrative duties or tasks currently completed by the CC could be appropriately performed by other staff. The CC is currently without a permanent, full-time PA who is trained to provide ACT specific administrative support functions such as: documentation and minute taking during the morning meetings, maintaining and setting up current email group lists, and building referral packets. Some CCs on other teams have reported greatly increasing time spent in direct member services by training the PA in these areas. • If all administrative duties are deemed essential, explore available options to document member contacts more effectively (i.e., administrative and/or technical supports that could improve opportunities for documentation).
H5	Continuity of Staffing	1 – 5 2	Over a two year period, 20 people left 13 positions for a staff turnover rate of 77%. Most notably, the team has had two Psychiatrists and four CCs in two years. Four people have served in the ES position and ILS position respectively. Three people have been employed in the RS position and PSS position respectively. Turnover may have had an effect on the ability of some members to benefit from the therapeutic relationship, as members interviewed said that while they believe staff are supportive and show concern for their needs, they experience the high turnover as a barrier to rapport and trust. New staff do not know members well enough and do not always follow through on action previously committed to by former staff. Moreover, members are not always certain who their case manager is.	• ACT staff turnover should be no more than 20% in two years. In addition to negatively affecting the therapeutic relationship between staff and members, high staff turnover also impairs staff cohesion and creates organization inefficiencies in terms of lost time and training. If not already in place, the provider should consider using staff exit interviews to determine factors contributing to high staff turnover. Staff satisfaction surveys should also be administered to gather feedback on factors that would (or currently) contribute to staff retention.

Item #	Item	Rating	Rating Rationale	Recommendations
H6	Staff Capacity	1 – 5 4	For the last 12 months, the ACT team has operated at 94% of full staff capacity. At the time of the review the position of ACT Specialist was vacant.	• See recommendation for H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT team has one full-time Psychiatrist whose time is 100% dedicated to ACT members. The Psychiatrist does not have responsibilities outside of the ACT team. She is accessible to staff by email and phone and has an open door policy for consultations. The Psychiatrist conducts home and hospital visits, and walks each member back to the team at the end of each clinic appointment. Staff said she knows how to talk to members, engaging them in discussions that elicit details that help her know them as individuals. The doctor often follows up member appointments with emails to the team with recommendations regarding areas of staff specialization.	
H8	Nurse on Team	1 – 5 5	Two Nurses work on the ACT team. Both see members in the office and on home and hospital visits, coordinating their schedules so that member needs are always covered. The Nurses do home visits to deliver medications or missed injections, provide coordination of care with PCPs, attend hospital visits, provide medication and health education and assist members with finding new doctors. Neither Nurse has duties outside the ACT team. Some staff expressed frustration that agency rules do not allow Nurses to transport members, noting that this rule does not seem to be in place on ACT teams outside Terros. Some staff would like for the Nurses to be able to transport and accompany members to PCP visits to ensure effective communication about member concerns and behavioral health issues.	

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H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team is served by two experienced Substance Abuse Specialists (SAS). The senior SAS has over 20 years experience working in substance abuse treatment, and was certified in another state as a substance abuse counselor. He has received trainings in substance abuse from both Terros and the RBHA. He also is a person with lived experience of substance abuse and recovery. The other SAS has been in the role only for about six months but is a veteran of the ACT team as the immediate past PSS. She previously received training in substance abuse through positions held as a halfway house manager and an employee of Catholic Charities, where she worked with survivors of sex trafficking who were also diagnosed with substance use disorders. She also reported receiving one substance abuse training with Terros and will soon receive a second one that is specific to ACT.	
H10	Vocational Specialist on Team	1 – 5 5	The ACT team employs both an Employment Specialist (ES) and a Rehabilitation Specialist (RS), each with over one year experience and training in vocational services. The ES has been with the ACT team for approximately three months at the time of the review, but had previously worked as the RS on this ACT team prior to moving out of state for a short time. She also reported previous trainings in vocational rehabilitation, though none with the current RBHA. The RS has been with the team for about one month prior to the review. Along with previous experience working in various behavioral health	

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			settings, she previously worked for United Way providing vocational rehabilitation services Indiana, where she assisted people with enrolling in recreational activities, provided job development activities and career exploration for adults who were returning to college.	
H11	Program Size	1 – 5 5	With 12 staff serving 93 members, the Townley ACT team is of sufficient size to provide coverage.	
O1	Explicit Admission Criteria	1 – 5 4	The Townley ACT team's admission criteria follow a written checklist provided by the RBHA. Screenings are done by the CC and the Psychiatrist. Three other designated staff also can do screenings, usually with people who are hospitalized. However, staff report that some admissions to the ACT team in the past do not appear to have met the criteria in all areas, and that some of those individuals present with more pronounced symptoms of personality disorders rather than serious mental illness, and may have been admitted under administrative pressures. The CC visits supportive teams to recruit members, and reaches out to SAs at Terros' other three clinics. The CC also talks to other CCs at the ACT CC meetings and recruits if other teams are at or over capacity. Staff said that referrals that come from supportive teams come with referral packets with all clinical notes. Psychiatric hospital referrals only come with a two page referral form. Staff report that recently the RBHA's expectation is that ACT teams have 72 hours to accept or reject ACT referrals. This window includes weekends and holidays when supportive teams are closed. The ACT team	• The ACT team should continue efforts to follow the written ACT admission criteria. The RBHA might consider more flexibility in timing to review ACT admissions to accommodate standard business hours to ensure that ACT staff have the opportunity to communicate any concerns related to appropriateness of admission with supportive teams or other most recent treatment providers.

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			in that case may not have adequate information to properly assess whether the person meets the criteria. In some cases, the supportive team does not agree with the hospital referral.	
O2	Intake Rate	1 – 5 5	The CC reported that the ACT team has accepted seven members in the last six month, with no greater than two admissions per month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management services, the Townley ACT team provides the full range of psychiatric services, housing services, and vocational services. The ACT team refers individual psychotherapy and individual substance abuse treatment to external providers. According to the CC, the ACT team does not refer to external employment services providers. At the time of the review, the ES was assisting approximately ten members with finding employment. The ES provides most employment services, with the exception of on-site job coaching. Members with job goals are referred to Rehabilitative Services Administration/Vocational Rehabilitation (Voc Rehab or VR). Staff reported that another ten members were referred by VR to external providers for general equivalency degree classes (GED) and job training such as sheltered workshops, or assistance finding employment. However, it was also reported that the PSS recently started a job skills training group. The CC plans to provide individual counseling and supportive therapy upon becoming a licensed associate counselor (LAC).	• ACT is designed to provide all services on the team. The agency should consider options to allow formal, individual psychotherapy, including individualized substance abuse counseling, to be performed on the ACT team. The agency should seek out opportunities to assist interested staff in obtaining any training, credentials, or clinical oversight required by the agency or other entity. • The ACT team, the agency and the RBHA should coordinate with VR to ensure that employment services are focused on finding competitive jobs in integrated settings that pay at least minimum wage, rather than trial work and sheltered workshop programs. The use of outside supported employment providers should be avoided. Many employment trainings, such as GED and computer skills, can be obtained through peer run organizations. When staff are sufficiently crossed trained, all should be able to provide the range of vocational services, including on-site job coaching.
O4	Responsibility for Crisis Services	1 – 5	The ACT team reports that they have full responsibility for crisis services. All ACT members	

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		5	are given a printed list of numbers to call in an emergency or crisis, including the ACT team crisis number, the Warm Line and the Crisis Line. In addition, the list includes the cell numbers of all ACT team staff. Staff said, "We go out during the day, sometimes in the middle of the night." Crisis may be about housing but also related to the presence of auditory hallucinations, anxiety about a medication change, anxiety about the holidays, psychosis, danger to self and/or others, or just needing to talk.	
O5	Responsibility for Hospital Admissions	1 – 5 5	Per review of the last ten psychiatric hospital admissions with the CC, the ACT team was involved in 100% of them. "I think it comes from seeing them and catching them in advance; we see the signs and try to get them in to see the Psychiatrist. We let members know that going to the hospital is not a bad thing." The CC said that most members notify them in advance if they intend to seek a psychiatric hospitalization, and staff then assist them with admission. The ACT team staff also bring concerns they have to the team's attention in morning meetings.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The ACT team was involved in 100% of the last ten psychiatric hospital discharges. "We are involved in the process by staying with them until admitted and being there when they are discharged." Upon discharge, the team is involved in coordinating their transportation home, the filling of prescriptions from the pharmacy, and scheduling their follow up appointment with the team Psychiatrist.	
O7	Time-unlimited	1 – 5	Townley ACT team services are mostly time-	• See Recommendation Item O1, Explicit

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	Services	4	unlimited. Members can remain on the ACT team as long as they wish. Said the CC, "We do not have a timeframe. Our Psychiatrist says that at least 18 months to two years of having insight to recognize and communicate their needs seems reasonable to consider stepdown." Some members ask to be stepped down to supportive, a lower level of care. "If we aren't offering anything that the member wants or can use, they might be ready." Staff reported that approximately seven members could be stepped down immediately to a supportive level of care, either because they have progressed in their treatment to require less intensive services or because they were not clinically appropriate at the time of admission. However, staff said the RBHA discourages transitioning individuals to lower levels of care. The CC expects that ten percent could graduate in the next 12 months. "We look at what brought them on the ACT team and how they have progressed since that time with activities of daily living (ADL)/independent living skills and symptom management." Staff noted that ACT services are voluntary, unless court ordered, and that members are not forced to accept them.	Admission Criteria. Graduation rates of 5% may suggest that some members did not meet ACT criteria at time of admission.
S1	Community-based Services	1 – 5 2	ACT staff interviewed estimated that, due to a very recent schedule change implemented by the CC (See Rationale, Item H2), staff spend 80% of their time in the community where "you learn the member's real habits and concerns." Staff said that at the clinic, members are on their "best behavior", but in the community, staff are able to observe situations that trigger problems.	• The ACT CC should monitor the outcome of the new staff schedule as related to percentage of time staff spend in the community. If percentage of time spent in the community remains below 80% the CC should consider further refining the new schedule to align more closely with another approach such as zone coverage, which some ACT teams have found to be helpful

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			It appears that the new schedule change is not yet reflected in the member electronic records. A review of ten member records found that only 27% of staff contacts with members occurred in the community. Some staff interviewed said that they preferred zone coverage because driving great distances across Maricopa County eats into time that could be spent with members providing direct services. Some staff also said they have trouble being timely with chart documentation, especially when they lack equipment such as laptops. One staff member noted that the previous clinic provider did not provide staff with the necessary tools and equipment.	in reducing unproductive staff travel time. • The agency should consider short and long-range planning goals to provide staff with necessary upgrades to equipment or tools that may allow them to be more mobile in the community. Technology such as Wi-Fi enabled laptops or tablets and Smart phones that allow staff to dictate notes directly into electronic records may free up time that staff could use to provide individualized, person-centered, skill-building and recovery focused interventions, as well as real-time observation, assessment and monitoring, in the community where learning best occurs.
S2	No Drop-out Policy	1 – 5 5	Staff make efforts to engage and see what services the member will accept if he or she refuses ACT services, and have a 98% member retention rate for the last 12 months. Two members left the team and could not be located. The ACT CC said that only one member has left the team without notification, and in this case, the member made the sudden decision to move out of state. The member's parent notified the team that her child had left the state. Staff offered to assist them with coordinating care in the new location but the parents assured staff that they had already arranged for services. In another case, a member left for another community without seeking a referral, but the ACT team was able to assist with the transfer of the member's medication prescription and obtain a release of information (ROI) in order to send an inter-regional transfer of services. "We help with coordinating with the	

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			mental health authority, help pack, confirm transportation and coordinate with payees when they are involved." The ACT team has also helped members look for housing and will communicate with out-of-state family members about anticipated needs.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The Terros ACT team follows a written eight week outreach strategy with all members who are out of contact with the team. The team sends letters to the members' last known address, attempts to obtain information or assistance from informal supports with which they have a ROI, check the Maricopa County Sheriff's Office (MCSO) website, contact with shelters, and visits the members' preferred locations, including peer run agencies where they go to use the food pantry and attend field trips. Staff said that most of the members are housed rather than homeless and that they "just aren't home so we show up early on the weekend when they are still sleeping." ACT staff also attempt to locate members by coordinating with formal supports such as payees and probation and parole officers. If after implementing the outreach strategy members still do not make contact, the ACT team closes services.	
S4	Intensity of Services	1 – 5 2	ACT members receive an average of 33.25 minutes of face-to-face staff contact per week, as per review of ten randomly selected member records. Travel time and challenges to timely documentation of member contacts may account for the lower amount of direct service time. While members expressed positive feelings about relationships with staff, some members interviewed complained that staff should be more	• Teams who achieve high fidelity in this area provide an average of two hours of direct member service per week. However, rather than focusing on a fixed amount of time spent with each member, staff should strive to provide face-to-face contacts that actively engage members in achieving their stated goals and immediate needs, that promote skill building, build upon strengths, and facilitate action on the part

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			attentive to them than they currently are.	of the member. Actual time with **each** member may be less than or greater than two hours per week but result in an average across the team of two hours. • Services delivered in the community offer staff the best opportunity to provide members high intensity services. See Recommendation for Item S1, Community-based services.
S5	Frequency of Contact	1 – 5 2	Per the record review, ACT members receive an average of 1.75 contacts per week from ACT staff. Of the five members interviewed, three reported an average of 2.6 contacts with staff in the previous week. Two other members interviewed were unspecific as to the number of staff contacts. One reported problems "getting people to see me last week" but praised his case manager for "taking care of business for me." The other member said, "It depends on what problems we have; otherwise we don't see them . . . we see them when they do a home check . . . I have a weekly shot."	• See Recommendations for Items S1, Community-based services and S4, Intensity of services.
S6	Work with Support System	1 – 5 2	Staff report that many ACT members reside with family, so the team has a good deal of contact with informal supports such as parents, spouses, significant others, and siblings. Many are involved in treatment, attending psychiatric appointments, seeking out assistance on behalf of the member, and offering the team updates on the member's presentation at home and in the community. The CC estimated that the team has contact with 20% of informal supports each month. Other staff reported that they have at least one contact with 40% - 50% of member supports. During the	• Ensure that contacts with members' informal supports are consistently entered into the member record. Upgrades to existing technology available to staff such as laptops equipped with Wi-Fi and Smart phone dictation apps may improve timeliness and completeness of documentation in this area. • Ensure that member records contain up-to-date ROIs, and that key member supports have copies of staff phone numbers. If not already understood, staff should be educated that they can receive and

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			morning meeting observed by the reviewers, staff mentioned six contacts with informal supports. Despite staff and member report, however, the record review revealed only .2 contacts per month for each member, possibly due to lack of timely documentation or those contacts not being properly recorded when supports are present during office or visits in the community.	document concerns reported by informal supports for whom the member has not signed an ROI. • Increasing community-based service delivery may result in increases in contact with informal support networks. For example, with member consent, staff can help a member locate and visit houses of worship, attend an AA meeting with a member, or provide education to a member's employer about psychiatric symptoms or effectively offering critical feedback.
S7	Individualized Substance Abuse Treatment	1 – 5 2	Although the ACT team benefits from two experienced and trained Substance Abuse Specialists, it does not currently provide formal, structured, individualized substance abuse treatment. The SASs report that they have about 20 – 25 members who receive informal sessions, lasting 15 – 20 minutes and focused on engagement, during home visits. Individual treatment is currently referred to the Terros Ladders program. Additionally, a site-based Terros clinician is available to provide individual substance abuse specific psychotherapy to members from all the clinic teams. The SASs do not know if the clinician is a Licensed Substance Abuse Counselor (LISAC) or what treatment model is used, but no ACT members are currently receiving services from that clinician.	• ACT teams should provide individualized substance abuse treatment within the team. It is recommended that the ACT team and the agency identify and reconcile any barriers, such as the provision for clinical oversight, prohibiting the SASs from providing that service.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	According to the SASs, 11 of the 49 members (22%) with a co-occurring disorder attend at least one substance abuse treatment group per month. At the time of the review, the senior SAS (1) was providing one substance abuse treatment group a	• Continue efforts to increase opportunities for members to attend ACT specific substance abuse treatment groups that follow the Integrated Dual Disorders Treatment model (IDDT). Consistently

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			week. That group, which lasts for one hour, is focused on maintenance and harm reduction. Approximately six to eight members attend any one group per week. The recently hired SAS (2), who previously provided a substance abuse group to the entire clinic, is slated to begin offering a second ACT specific substance abuse group the week after the review. The SAS(2) said her group follows the SAMHSA model of anger management and substance abuse, and will utilize tools found on the Therapist Aide website and 12 step interventions. The SAS spoke very highly of a new curriculum guide provided by Terros, "Group Treatment for Substance Abuse: A Stages of Change Manual". A brief review of the manual by reviewers found evidence of substantive text detailing rationale and explanations of concepts and treatment interventions that appeared to follow the integrated treatment of dual disorders model, including an emphasis on a stage-wise approach, stages of change, motivation for change.	offering at least two groups led by both SASs increases the opportunities and options for engagement in substance abuse treatment. • Continue with efforts to cross train other staff specialists in substance abuse treatment and the co-occurring model so that all staff can take advantage of opportunities to immediately engagement members in discussions about attending ACT substance abuse groups.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The SAS describe using a variety of approaches in treating members with a co-occurring disorder. Both agreed that abstinence, while a desirable goal, is not realistic for most members. Although interviews suggest that not all staff are completely on board with the emphasis on harm reduction over abstinence, staff understand that the agency endorses the former. The SASs work on individual plans to help members achieve goals, such as housing, effective coping skills, and connection to outside sources of support such as alcohol-free activities for socialization. The SASs said that they focus engagement and treatment	• The ACT team should continue implementation of the COD model with current ACT staff, with focus on ensuring that both SASs are prepared to cross-train other staff. Additionally, regular individual and group supervision, including in the context of the morning meeting, may be necessary for successful transition to the model. • At the team, agency and RBHA level, continue efforts to provide education and training in COD model as a stage-wise

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			"where they are", explaining this to mean the member's readiness or stage of change. "I also reflect their thoughts and feelings back to them for self-assessment. We also use activities to focus their thoughts to make decisions." One SAS cited the work of Terence Gorski and Relapse Prevention Therapy as influential in efforts to help members discover their *personal relapse pattern*. The SASs said that members with co-occurring disorders need as many avenues of support as possible including 12-step programs such as Alcoholics Anonymous or Crystal Meth Anonymous. Detox may be necessary for those who are visibly intoxicated and "strung out", and some may need an inpatient treatment program. Some staff interviewed said the ACT team would benefit from additional, ongoing training in the COD model and the American Society of Addictive Medicine (ASAM) criteria. Similarly, some staff have not had the opportunity to be thoroughly cross-trained in substance abuse.	treatment approach in which different services or interventions are used at different stages of treatment. As noted in Item S8, the substance abuse group treatment manual provided by Terros was praised by the SASs and may be a useful resource for ongoing training and education of the rest of the ACT staff.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team benefits from a PSS who is recognized as a full member of the professional team with responsibilities equal to those of other staff. The PSS is described as particularly effective in working with difficult to engage members and providing education, guidance and feedback to family supports. Additionally, the newly hired SAS previously served as the ACT PSS, and uses her lived experience of recovery to engage members in discussions about substance use treatment. Finally, both the senior SAS and the CC have lived experience in recovery or are supporting family in recovery.	
Total Score:		**3.96**		

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	2
5. Continuity of Staffing	1-5	2
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	4
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5

5. Responsibility for Hospital Admissions	1-5	5
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	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	2
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	**111/28 = 3.96**	
Highest Possible Score	**5**	