ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: April 28, 2016

To: Colleen Roberts, ACT Capitol Center Clinical Coordinator

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ADHS Fidelity Reviewers

Method

On April 11-12, 2016, T.J. Eggsware and Jeni Serrano completed a review of the La Frontera-EMPACT Capitol Center 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 Capitol Center ACT team was managed through the People of Color Network (PCN) when the program was reviewed May 6-7, 2015. At the end of September, 2015, PCN services ceased and management transitioned to La Frontera-EMPACT. On October 1, 2015, full responsibility of the Capitol Center and Comunidad clinics was assumed by La Frontera-EMPACT. This review focuses on the ACT services through La Frontera-EMPACT, but the timeframe of the review also includes a period when the team was managed through PCN. La Frontera-EMPACT provides behavioral health services to children, adults, and families. Outpatient and inpatient services include: counseling, psychiatric services, substance abuse treatment, trauma healing, crisis intervention, supportive services, and services for adults with a serious mental illness.

The individuals served through the agency are referred to as *patients*, *clients* or *recipients*, 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 morning team meeting on April 11, 2016;
- Individual interview with Team Leader/ACT Clinical Coordinator (CC);
- Individual interviews with the Substance Abuse Specialist (SAS), the Independent Living Skills (ILS) Specialist and the Peer Support Specialist (PSS);
- Group interview with three members who receive ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system;
- Review of agency documents provided or referenced by ACT staff, including: ACT morning meeting tracking, tracking of member substance use stage of change; the *ACT Admission Screening* criteria, *ACT Eligibility Screening Tool,* and *ACT Operational Manual* developed by the Regional Behavioral Health Authority (RBHA).

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

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team has a member to staff ratio of 9:1, which excludes the Psychiatrist and Program Assistant. Including the Psychiatrist, the team consists of 11 full time staff for 92 members.
- The team meets four days a week, reviewing each member at each meeting; the Nurse and Psychiatrist attend team morning meetings on three of the four days. The team uses a morning meeting tracking sheet to track member data and statuses.
- The Psychiatrist and Nurse provide services to members in the community one day a week. The Psychiatrist on the team has been on the team since July 2005. The Psychiatrist and Nurse have no other administrative duties at the clinic, and rarely see members from other teams; the majority of their time is dedicated directly to serving ACT members. Both contribute during morning meeting discussions, and work with the team to plan interventions.
- Based on interviews, members are familiar with staff specialty positions and duties, and staff share responsibility for member contact.
- The team has established admission criteria; there are no administrative pressures to accept members who were assessed by the team to not meet identified criteria.
- The team benefits from a fully-integrated Peer Support Specialist (PSS).

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

- The agency needs to monitor duties and activities of the CC, with a goal of at least 50% of the CC's time spent providing direct services to members; eliminate any responsibilities that are not essential, and determine what essential duties can be transitioned to other agency staff.
- Based on records reviewed, the team provides low intensity and frequency of services to members. ACT services should be delivered primarily in the community (where they are better retained) and not the office setting. The team should identify what services are currently delivered in the clinic setting that can be provided to members in the community. For example, treatment groups that address substance use challenges are likely to occur in the clinic setting, but the agency should carefully define the expected outcome of other groups before implementation. Member contacts should be increased with multiple staff on the team, striving to provide, on average, at least four contacts totaling at least two hours per week per member.
- Staff should be trained, empowered, and expected to fill the roles within their area of specialization and cross-train each other so that staff can respond to member needs. Improving the capacity of staff on the team to directly provide a wider range of treatment services may result in increased intensity, frequency, and community-based services to members. The ACT team is not providing the full

complement of expected services in the areas of employment support services, counseling, and housing support services.

- The team needs to focus efforts on involving members' identified support system; encourage members to identify their informal supports (i.e., people not paid to support members) such as family, landlords, neighbors, friends, etc. and then assist them in acquiring the knowledge, resources and skills needed to support members. Consider developing a family psychoeducational group where families have the opportunity to expand their social networks, support each other, and learn techniques from each other on how to support members. Some teams elect to involve the team PSS in co-facilitating these groups.
- Engage members with substance use challenges to participate in individual and group treatment through the team. Ensure ongoing supervision and training is provided to SAS staff, and empower SAS staff to cross train other staff in the use of proven intervention techniques. The team should monitor the use of a recognized integrated dual diagnosis treatment model to standardize the team approach when working with members with substance use challenges. Prior to referrals to sober living residences, ensure it is the member's first choice of treatment and that the living situation aligns with a dual diagnosis treatment approach.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	Excluding the Psychiatrist and Program Assistant, the team consists of ten staff serving 92 members. Although all staff do not carry an identified primary caseload (e.g., Nurse), staff share responsibility for treatment. The member to staff ratio of 9:1 is within the preferred fidelity measure.	
H2	Team Approach	1 – 5 (3)	The team uses a rotation schedule for specialist staff contact with members based on areas where members reside, or are located (e.g., hospitals, jails, or other facilities located in a geographic zone). Staff estimates approximately 85% of members meet with more than one ACT staff in a typical two week period based on morning meeting tracking. Other staff report having multiple contacts with different members from week to week, ranging from approximately 40 – 50 members a week, or about 10 – 18 members per day, depending on the zone assigned that week. To confirm the level of team responsibility for each member, ten member records were sampled. Sixty percent of members reviewed had face-to-face contact with multiple staff, over a two week period.	• Ensure the majority of members have contact with more than one staff over a two-week period. • Continue to monitor the zone coverage practice to determine if the approach should be adapted. Some staff report that challenges occur when assisting a member with a task, but have to transition the task to another staff when zone coverage changes occur. If members face unique circumstances, determine if specialty staff may more appropriately provide those services. For example, if a member was seeking housing, the HS or ILS may be best equipped to assist rather than transiting the task from staff-to-staff from week-to-week.
H3	Program Meeting	1 – 5 (5)	The full team meets daily in the morning Monday through Wednesday, does not meet Thursday, and on Friday all team members meet with the exception of the Nurse and Doctor. All members on the team are discussed, even if only briefly. The meeting observed on Monday April 11, 2016 lasted just under two hours. Staff reports that on Mondays, the meetings tend to last longer than normal (about an hour and a half) due to the	• Continue to monitor the structure and pace of discussion during the morning meeting to ensure the meeting duration does not divert staff from providing direct services to members in the community, but allows adequate time for discussion of members served.

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			Psychiatrist and Nurse not having been in the meeting on Fridays, and catching up on review of members from the weekend.	
H4	Practicing ACT Leader	1 – 5 (3)	Since the prior year's review, the agency hired an experienced CC who reports about 20% of her time is spent providing services directly to members currently assigned to the ACT team. Based on data provided over a month timeframe, which included two days when the CC was not at work, the CC provided direct services about 12% of the time. Based on documentation in ten member records reviewed, the CC routinely provides services, including transporting members, conducting home visits, engaging members to participate in groups, etc. These CC services accounted for about 5% of all direct services over the month timeframe reviewed in those ten records.	• The CC should continue efforts to provide direct services to members at least 50% of the time. There may be opportunities for the CC to model interventions, or provide guidance to staff in the field during member interactions, and more importantly, for the CC to maintain contact with members to share treatment responsibilities with direct service staff. • Review administrative tasks assigned to the CC to determine if all are essential to the CC role referenced in the SAMHSA ACT model, and whether other responsibilities can be transitioned to other supports such as the Program Assistant or other clinic staff.
H5	Continuity of Staffing	1 – 5 (2)	As noted above, management of the ACT team transitioned from PCN to La Frontera-EMPACT when PCN operations ceased, but the CC reported this did not appear to significantly impact the collection of data. When fully staffed, the team has 12 positions. In the two-year period prior to the review, 19 staff left the team, a 79% turnover rate. In the scope of this review, it is difficult to ascertain the extent events related to the provider transition impacted continuity of staffing.	• If not in place, consider conducting targeted satisfaction surveys with ACT staff to determine what is working to retain current staff, as well as exit surveys to determine reasons staff leave positions. • The agency should review staff performance expectations to ensure they align with a functioning ACT team and make every effort to support staff retention in order to provide consistent services to members. Maintaining consistent staffing enhances team cohesion and the therapeutic relationships with members.
H6	Staff Capacity	1 – 5 (3)	The program had 34 total position vacancies in the 12 month review period, with more than half of those vacancies in the six month period prior to	• The agency should continue to offer trainings and support in order to maintain staff.

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			the transition from PCN to La Frontera-EMPACT, and fewer vacancies in recent months. It is difficult to ascertain how many of the 34 vacancies were tied directly to events leading up the agency transition in October 2015. Over the 12 month period, the program operated at approximately 76% staffing.	• See also recommendation for H5, Continuity of Staffing, for additional information.
H7	Psychiatrist on Team	1 – 5 (5)	The team has one full-time Psychiatrist who provides treatment, medication prescription and monitoring for ACT members. The Psychiatrist works four ten-hour days and attends the morning meetings three days a week. Staff confirms he is accessible, even on his flex-day. On Thursdays, the Psychiatrist, the Nurse, and another staff meet with members in the community. During the morning meeting observed, the Psychiatrist was actively involved, discussing services he delivered in the community, and working with other ACT staff to plan services to members.	
H8	Nurse on Team	1 – 5 (3)	There is one full-time Nurse on the team whose duties include conducting home visits, administering medications, attending morning meetings, and offering education to the members and the staff. Per staff report, the Nurse is available to the team and attends morning meetings three days a week, as well as accompanying the Psychiatrist in the community on Thursdays.	• The agency should hire a second nurse for the team. A second Nurse could provide additional flexibility for scheduling and improve opportunities to provide health education and care in and outside of the clinic. • Some teams elect to assign a small number of members directly to the Nurse, often those members with chronic or more challenging medical issues. • Some teams elect to include Nurses in medication observation rotation; for this team that may include participation in the zone contact assignment. • Some ACT Nurses provide services such as helping members explore housing options,

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				assisting members with benefit paperwork, helping members move residences, transporting members, etc. where there may be other opportunities to provide health education.
H9	Substance Abuse Specialist on Team	1 – 5 (4)	Two SAS staff members are assigned to the team. One of the staff has worked on ACT teams in the position of SAS for over seven years. Her experience and training includes working in sober living settings, experience with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and the 12-step model, as well as some training through the RBHA. The second SAS has a Master of Social Work, with prior experience in inpatient and outpatient settings, but it appears his experience in substance abuse treatment was ancillary to other duties.	• The agency and RHBA should train and support the SAS staff in dual diagnoses treatment. • The agency should ensure the SAS staff receives supervision and training by someone qualified in substance use treatment. Training and guidance should focus on core responsibilities, including: assessing stage of change, guiding and implementing treatment approaches that align with the identified stage of change or readiness level, motivational interviewing, and relapse prevention support. Attempting to evoke guilt, shaming, or coercive approaches should be discouraged.
H10	Vocational Specialist on Team	1 – 5 (3)	The team currently has two staff that fall under the Vocational Specialists designation: one Employment Specialist (ES) and one Rehabilitation Specialist (RS). Per report, the RS has prior experience as an RS. The ES worked on a Supportive level case management team, and has prior ACT experience. Both staff attend specialty-specific trainings offered by the RBHA. Though the RS and ES engage members in socialization, group activities, and member run programs, it does not appear both staff have at least one year of training and experience in vocational services that enable members to find and keep jobs in integrated work settings.	• The agency should ensure both vocational support staff receive supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings. Vocational Specialist duties include: assisting members directly with job searches and job placement, assisting members who transition back to school or classes, job coaching & follow along supports, benefits counseling, and cross training other staff.

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H11	Program Size	1 – 5 (5)	Excluding the Program Assistant, the team consists of 11 full time staff for 92 members. The program is of sufficient size to provide necessary staffing coverage; the only vacancy is the second Nurse position.	
O1	Explicit Admission Criteria	1 – 5 (5)	The ACT team does not actively recruit; the CC reports the team receives referrals from various sources including jails, hospitals, and other teams. The CC reports she educates system partners about ACT services and how they differ from a more intense service (e.g., 24 hour one-on-one services). Referrals are screened by the CC or another ACT staff using the *ACT Admission Screening* criteria developed by the RBHA, as well as the team Psychiatrist; the team makes the final determination regarding admissions to the team, with no administrative pressures to accept referrals the team does not feel are appropriate.	• Consider evaluating and expanding recruitment efforts; the team is of adequate program size, and caseloads are within optimal fidelity measures to accept more members.
O2	Intake Rate	1 – 5 (5)	Based on team report, there were no more than five admissions in any of the six months prior to the review. There were no admissions in November 2015, two admissions in both December 2015 and January 2016, and three admissions in February and March 2016; the peak monthly intake rate was five in October 2015.	
O3	Full Responsibility for Treatment Services	1 – 5 (3)	Members are aware of a spectrum of services available through the team and that staff have different specialties; one member reported that if he doesn't see his primary CM weekly, he does see someone on the team that knows him. Some staff developed brochures/handouts that explain their position, duties, and contact information. In addition to case management, the team directly provides psychiatric services. The ACT team offers	• The ACT team should closely evaluate and track referrals to external providers. Optimally the team should directly provide a spectrum of services, including vocational, housing and substance abuse supports, 90% or more of the time, avoiding external referrals and unnecessary duplication of services that should be provided by a fully functioning ACT team. • The agency should continue to review

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			individual and group substance abuse treatment; most members who receive support in this area receive the service through the team, though some members are in settings where supports that overlap with ACT services may be provided, including residential treatment, and sober living residences. It does not appear the ACT team provides 90% or more of housing directly. The ACT team explores options for housing and offers support (e.g., independent living skill prompting and education) to members in the community. However, about 25% of members are in staffed residences (e.g., Flex-Care/residential, half-way houses, sober living residences) with staff support that appears to overlap with ACT support services, and one member is pending placement. Staff report that they do not provide counseling because none of them are licensed, but no members were identified who receive the service through any outside providers. Although the team engages members to consider socialization and group activities, there is not enough data to support if vocational staff is offering vocational services that enable members to find and keep jobs in integrated work settings. For example, one member reported staff discussed back to work programs with him, but it was not clear if the team directly assisted with work exploration. The ES reportedly works with four members who are seeking employment, but there were some members who received services or were pending referral to external employment support services (e.g., Work Adjustment Training).	training and supervision options to ensure staff designated with a specialty area receives monitoring, support, and supervision specific to their role. See also recommendation for H10, Vocational Specialist on Team, and H9, Substance Abuse Specialist on Team, for additional information. • Consider providing staff position summaries and contact information, with staff names, for all ACT staff to members. As new staff are added, the information should be updated so members are aware of their current clinical team supports.

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O4	Responsibility for Crisis Services	1 – 5 (5)	The team is responsible for crisis support, and the team schedules overlap to allow for 24 hour coverage, including the weekends. A laminated card is provided to members that lists specialty position staff contact numbers, the team's on-call number, the RBHA customer service line, and the clinic address. Members are encouraged to contact the team rather than the crisis line, and staff goes into the field to support members if a crisis may arise. Staff reports the team has someone on-call 24 hours a day and the CC serves as the backup on-call. Staff report they have the resources (e.g., laptops, cell phones) to provide these services. The team is phasing out its clinic-based staff who handles crisis or issues at the clinic (i.e., blue dot), and filtering calls to the team cell phones so they can provide services in the community.	• The agency and RBHA should monitor the process of transitioning the clinic-based staff who handles crisis situations to a community-based model to determine if the approach can be adopted by other ACT teams.
O5	Responsibility for Hospital Admissions	1 – 5 (4)	Prior to a member's hospital admission, the team determines if a member is voluntary, and if they are willing to meet with the Psychiatrist or be triaged with the Nurse. The team reports they are involved in most hospital admissions, but the team may not always be informed or aware of admissions; some members self-admit. Based on review with the CC, the team was involved in 70% of recent admissions. When the team was involved in admission, they usually completed an application for court-ordered evaluation (COE) or amended members mandated for court-ordered treatment (COT). It is not clear if the agency has a separate hospital admissions protocol for ACT teams; the team relies on the RBHA *ACT Operational Manual.*	• The team should work with each member and their support network to review how the team can support them to potentially divert, or to assist in a hospital admission, if the need should arise. Educate inpatient staff and administrators about the ACT team, including contact information and team structure.
O6	Responsibility for Hospital Discharge	1 – 5 (5)	Staff report they maintain frequent contact with members who are inpatient, meeting with them	

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	Planning		every 72 hours, and increasing contact in some cases when they are closer to discharging. The Psychiatrist completes a phone consultation with the inpatient treating doctor, and staff maintains contact with inpatient Social Workers. Staff reports they coordinate with inpatient staff to ensure members have medications at discharge, make sure members have a safe place to go at discharge, and facilitate an appointment with the Psychiatrist within 72 hours of discharge. Members who recently discharged were discussed in the morning meeting, and staff report they complete face-to-face contact with members for seven days post-discharge, including weekends. Based on review with the CC, the team was involved in all ten of the most recent discharges.	
O7	Time-unlimited Services	1 – 5 (4)	In the past 12-month period prior to review, five members graduated, and the CC estimates 5-10% of members are pending or expected to graduate in the next 12 months. During the morning meeting observed, some members were discussed who were in the process or would be considered for Supportive service level (i.e., graduation). It appears most members are served through the team on a time-unlimited basis, with about 5-10% expected to graduate annually.	• The agency should monitor the number of members transitioned off the team to ensure most members are served on a time-unlimited basis.
S1	Community-based Services	1 – 5 (3)	Staff members on the team estimate 60-80% of their time is spent in the community. Based on records, the median ratio of community-based services was 50% with six members who received 50% or less of contacts in the community. Four members received all services in the community, but three of those members received, on average, less than one contact per week. It is not clear if all services were documented. There was some documentation that indicated staff was not aware	• The program should seek opportunities to increase in-vivo services. Consider eliminating practices that require members come to the clinic (e.g., bus pass every seven days versus a monthly pass). Supportive housing services, assisting with employment goals, peer support services, and other skill development activities should occur in the community rather than

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			of member status. For example, staff attempting to visit with a member at home who other staff documented was inpatient.	the clinic whenever possible. • Any plans to develop new groups at the clinic, not directly related to substance use treatment groups, should include discussion of how the group service is more beneficial than providing individual services to members in their communities. • Ensure all direct services are documented in a timely manner; review agency policy to ensure the expectation is outlined, and if not, consider developing a policy to ensure timely documentation occurs.
S2	No Drop-out Policy	1 – 5 (5)	The ACT CC reports that none of the members who left the team were discharged due to refusing services, but four members moved without referral. The team offered to assist one of the members to connect with services in the new state but they declined; one member left the state without informing the team; and two members left prior to the current CC joining the team, so detailed information was not available. Other members who transitioned off the team or closed that were not factored into scoring in this area include: transfer of services to the Arizona Long Term Care System, transfer due to admission to the Arizona State Hospital, incarceration in the Arizona Department of Corrections, and graduations from the team. The team retained 96% of the members in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 (4)	It is not clear if the team follows a formal case-closure and re-engagement policy. It was reported staff generally perform multiple outreach attempts over the course of eight weeks prior to closure. Staff reports engagement mechanisms that include: community outreach, coordination with	• If the agency has a formal written policy or process for outreach and engagement, ensure it is reviewed with staff; ensure outreach occurs for members who are not in regular contact with the team, and that all services are documented in a timely

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			payees, coordination with probation or parole, contact with family or friends (if known and if the program has a release of information), and offers to adjust to a lower frequency of contact if the member prefers less than four times a week. During the morning meeting observed the team discussed some members they were outreaching, and in some cases plans to step members down to Supportive level of service, but it was not clear in all cases if this was due to improvement (i.e., graduation) or in part due to some members not engaging in ACT services with the team. In one record reviewed, staff informed a Probation Officer (PO) when a member left a sober living facility.	manner. • Ensure staff distinguish the benefit of coordination with formal supports (e.g., Probation or Parole Officers) to help members maintain stability in the community versus reporting potential probation or parole infractions to POs that could lead to incarceration.
S4	Intensity of Services	1 – 5 (2)	Based on ten records reviewed, the team provides a median of 38.38 minutes of services to members per week. Service intensity ranged from an average of 6.75 to 165 minutes per week; six members received less than 45 minutes on average per week, and only two members received more than two hours of service per week.	• The team should make a focus effort to increase the duration of contact with members, and ensure all services are documented. Although some members may receive less than two hours per week, the average across all members should be *at least* two hours per week. The team CC should periodically track service time per staff to ensure this is improving. • Decreasing the reliance on other providers for some services (e.g., residential/Flex-Care treatment), and increasing other services (e.g., substance abuse treatment, or vocational supports) should result in a higher average intensity of services delivered by ACT staff to members on the team. The ACT model promotes psychiatric stability by providing relevant services to members in an intense manner. See also

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				recommendation for O3, Full Responsibility for Treatment Services, for additional information.
S5	Frequency of Contact	1 – 5 (2)	Based on ten records reviewed, the team median was 1.75 contacts per member per week. When at the clinic, members often see multiple staff. Some members report contact with Nurse and Psychiatrist once a month, as well as various staff (i.e., team specialists or staff they identify as their Case Manager) in the community; members are aware they are served by a team.	• Well-functioning ACT teams provide an average of four face-to-face contacts for each member, each week. The team should focus on increasing contacts with members, preferably in conjunction with increased community-based services. Ensure all contacts are documented. • The team CC should periodically track member contacts per staff to ensure this is improving.
S6	Work with Support System	1 – 5 (2)	The data provided implies the ACT team has occasional interaction with members' support systems. During the review, the CC reported approximately 47% of members on the team have supports. The CC reported the team has contact multiple times weekly for some informal supports, but less frequently with others, averaging contact about twice a month. The CC supplied data after the review with a higher average frequency of contact with informal supports (approximately 1.9 per month) but this data was not factored into this area as it was provided after the review. During interviews, staff had some difficulty estimating the average monthly contact with informal supports for the entire team. For their primary caseloads, one provided data that suggest about .5 average contacts a month with informal supports, and another staff reported he sometimes has about eight to ten informal support contacts per day. Neither records, nor discussion in the morning meeting observed supports the higher frequency	• Continue to ensure ACT staff reviews with members the potential benefits of engagement with informal supports, and attempt to secure a Release of Information (ROI) allowing staff to contact identified supports. This may allow staff opportunities to educate informal supports about how the illness can impact the member. • If a member declines to allow staff to make contact with informal supports this should be documented in the record. However, staff can generally receive information from informal supports and may be able to share limited data with known supports in some situations. If necessary, review confidentiality guidelines when developing an agency plan to engage informal supports. • Focus on documenting team contacts with member support systems in a consistent fashion, to ensure this measure is being accurately captured. For example, consider

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			of contact estimated by some of the staff. The ten member records reviewed indicated that the team averaged less than .5 contacts per month with members' support systems. The team discussed informal supports for about 16% of the members during the morning meeting observed, though it was not clear if the team was in contact with all informal supports, or the frequency of contact. Assuming weekly contact occurs with the informal supports for the members discussed during the meeting observed; it results in an average of .7 contacts a month. Based on data provided by the CC during review, records reviewed, report of staff, and observation of the morning meeting it is estimated the team has less than one contact per month with informal supports, on average, for members on the team.	tracking staff contact with informal supports, engagement efforts, etc. in the morning meeting. • Consider developing a family psychoeducational group where families have the opportunity to expand their social networks, support each other, and learn techniques from each other on how to support members. This will serve to connect informal supports with a support network of their own, but give staff opportunities to offer problem-solving strategies to address challenges that may result from the illness.
S7	Individualized Substance Abuse Treatment	1 – 5 (3)	At this time, the team provides a limited amount of regularly-scheduled, individualized co-occurring treatment to members. Of the 60 members with a dual diagnosis, 30 of them receive some level of engagement from one of the SASs. Treatment is focused on engagement, may be combined with the regular home visits, and sessions usually last from 25-30 minutes.	• Ensure staff is trained and receives ongoing supervision to provide substance abuse treatment to the population served. • Continue efforts to engage members in treatment through the team. Substance abuse treatment should be dedicated and individualized, not just interventions during home visits, and should preferably follow a proven dual treatment model.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	The team offers one hour long substance use treatment group weekly. Based on staff report, a core group of about four to five members attend weekly, and approximately 17% of members with substance use challenges attend at least once monthly. The SAS utilizes a curriculum developed by the RBHA as a foundation. The SAS also relies on prior employment experience, and SAMHSA materials such as the Center for Substance Abuse	• Continue efforts to engage members in treatment through the team. Promote the new group and explore engagement strategies that will encourage member attendance. (e.g., open house, motivational interviewing, etc.); track member attendance via sign-in sheets or other mechanisms. • Provide training, supervision and guidance

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			Treatment's *Enhancing Motivation for Change in Substance Abuse Treatment,* part of the Treatment Improvement Protocol (TIP) Series, to guide her group facilitation approach.	to SAS staff as they implement an integrated dual diagnosis treatment recovery program; consider tracking member outcomes for members who participate in group to determine if targeted training or supervision should be provided to staff.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (3)	The team generally uses a stage-wise treatment model as the foundation for most member interventions. Staff interviewed and observed principally focused on a transtheoretical model (i.e., stages of change). SAS staff is familiar with the 12-step model, may refer to AA or NA as an aspect of treatment, but it is not the only option offered, and they may offer to attend with members. Member stage of change is discussed during morning meeting, and staff reportedly utilizes motivational interviewing techniques. Abstinence is an ultimate goal, but staff report they encourage harm reduction, celebrating steps toward reduced use. Some members reside in external programs (i.e., 24 or 16 hour residential) identified as co-occurring treatment facilities. However, other members are in residences where sobriety is mandated, and it was not clear if placement in those residences was based on the preferences of the members. For example, one member was referred to sober living facilities but requested independent living, citing she felt the issue at hand related to housing. In the AM meeting it was discussed that someone wanted a job, but it was noted he would need to stop using substances first. Staff report this is generally not the approach of the team, but cited substance use as a barrier to	• Focus efforts on implementing a consistent, harm-reduction based treatment model that can unify the team approach; ensure SAS staff receives ongoing supervision and guidance so they are empowered to cross train other staff. • Educate all staff on the principles of dual diagnosis treatment, constantly implementing the training and support needed to entrench its values into the team's culture. Standardize the team's integrated dual diagnosis treatment approach, and ensure the team language aligns with a recovery approach. Attempting to evoke guilt, shaming, or coercive approaches should be discouraged. • Establish methods for tracking member progress through the stages associated with a dual diagnosis treatment model. As members improve (or experience recurrences of use), SAS staff can communicate the effective interventions associated with that particular "stage of change" to other staff with the intention of improving treatment planning outcomes and increasing member participation in substance abuse treatment.

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			seeking employment. Additionally, one staff reported shaming a member who voiced their dislike of a type of housing where the team referred the member.	
S10	Role of Consumers on Treatment Team	1 – 5 (5)	The team has a fully integrated Peer Support Specialist (PSS) who provides direct services to members. Staff report, and members confirm, that the PSS shares his personal experiences with members as he seeks to support their recovery. The PSS also facilitates a group where members can connect to provide mutual support.	
Total Score:		**3.68**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	3
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	3
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	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
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	3
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.68**	
Highest Possible Score	**5**	