ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: October 31, 2016
*November 8, 2016

To: Jennifer Nye, Senior Director of Recovery Clinic Services

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

Method

*As of November 8, 2016, this fidelity report has been revised due to a slight error that was made during final editing. The total score has been updated on p. 17 and p. 19 of this report.

On September 27 -28, 2016, Karen Voyer-Caravona and Jeni Serrano completed a review of the Terros West McDowell 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 ACT team at the West McDowell clinic is operated by Terros, a comprehensive healthcare organization that strives to integrate behavioral health and primary medical care. Terros acquired the ACT team and several other clinical teams from a different provider just prior to the previous year's fidelity review. Previous and subsequent to that transition, the team experienced significant staff turnover, which may have challenged the ACT team's efforts to align fully with multiple items on the ACT fidelity scale.

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

- Observation of a daily ACT team meeting;
- Individual interview with team leader/Clinical Coordinator (CC);
- Individual interviews with Substance Abuse Specialist (SAS), the Rehabilitation Specialist (RS), and the ACT Specialist (AS);
- Group interview with nine members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Review of team documents: *ACT Eligibility Tool*, *Eight Week Outreach Engagement* strategy; CC encounter log, and *ACT Morning Meeting* roster.

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 ACT team maintains a low member to staff ration of about 10:1.
- The ACT team is of sufficient size to provide necessary staffing and diversity.
- In the six months preceding the current review, the ACT team admitted no more than two members per month for a total of eight.
- The ACT team provides time unlimited services. Graduations to a lower level of care are offered according to a written criteria reflecting the member's ability to maintain in the community with minimal case management supports. Members may remain on the ACT team as long as they find the relationship with the team beneficial for their recovery.

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

- The agency should focus on staff retention and reducing staff turnover to no more than 20% in 24 months. The rate for the period under current review was 96%. This level of staff turnover may have compromised fidelity in other areas of this review, including, but not limited to, *substance abuse specialist on the team* (H9), *vocational specialist on the team* (H10), and *full responsibility for treatment services* (O3).
- The ACT team should provide necessary staff training and resources, so all services can be provided directly by the team. Previous education, training, and work experience should be factored into filling future vacancies, particularly for the Substance Abuse Specialist (SAS), Employment Specialist (ES), Rehabilitation Specialist (RS), and Housing Specialist (HS) positions.
- The ACT team should provide regular reminders, prompts, and education to members about the ACT team's role as the primary responders to crisis situation and the importance of using the team when seeking a psychiatric hospitalization. Strengthening rapport and recovery oriented engagement with members and their support systems may improve fidelity in this area.
- The ACT team and the agency should increase the frequency and intensity of community-based services with members. The

ACT team should avoid clinic-located interventions and groups, other than those specifically described within the EBP of ACT (e.g. substance abuse groups). Rather than focusing on a minimum of four contacts totaling two hours per week for each member, the team should redirect efforts to providing meaningful engagements, geared toward assisting members' individualized goals and objectives. Frequency and intensity across the whole team should *average* four contacts, and two hours per week, with some members receiving less or substantially more based on current needs.

- Hire a Peer Support Specialist to ensure a recovery focus through the continuous recognition and attention to the member perspective and voice, and to help facilitate engagement of informal support systems.

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 ten staff for twelve positions serving 95 members. Excluding the Psychiatrist, the member to staff ratio was calculated at 10:1.	
H2	Team Approach	1 – 5 3	Members interviewed reported that they see two to three different staff members weekly, either at the clinic or at their residence. According to the CC, 75% - 80% of members see more than one staff member in a two week period. The CC said that the team is experimenting with providing coverage by regions and zones to reduce travel time between visits to members. Per a review of ten randomly selected member records, 50% of ACT members see more than one staff in a two week period. Interviews of staff and members indicate that members have primary case managers and that those primaries first focus on seeing those members on their caseloads. Staff interviewed also reported being required to have eight billable contacts per day and that they try to get as many done as possible in one geographical location. Some staff reported difficulties in timely documentation of contact.	• Increase the percentage of members seeing more than one staff member in a two week period to 90% or more. Maintaining full staffing may result in improvement in this area. • The CC should periodically review member records to ensure encounters with members are properly recorded. The ACT team and the agency should collaborate to find solutions to any identified barriers to documenting face-to-face staff/member contacts in records on time.
H3	Program Meeting	1 – 5 5	Staff interviewed said that the team meets five days per week, Monday through Friday, as a full team for one to 1.5 hours. The CC reported that the team recently transitioned from a four day/ten	• The CC should mentor the team in the program meeting to focus discussion on not only current status but also on person-centered planning and recovery oriented

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			hour work week to a standard five day work week and now is able to meet as a full team daily. The CC said that the team tries to go through the entire list each day; on Wednesdays, the team may go through some members more in depth. At the morning meeting observed by the reviewers, seven staff were present, including the Psychiatrist. The CC began the meeting by reviewing crisis calls from the prior day, followed by a review of hospitalized members and the Psychiatrist's and Nurses' schedules. All members were discussed, with focus on medication adherence, treatment compliance, sobriety/substance use, and whether members are coming into the clinic. It was unclear to the reviewers from the meeting how staff function within their areas of specialization to support person-centered recovery goals.	rehabilitation efforts that empower staff to provide services in their areas of specialization.
H4	Practicing ACT Leader	1 – 5 3	The CC reported that he spends 20% - 30% of his time providing direct member services, in the clinic and in the community, doing home visits and participating in hospital staffings. The CC said that he conducts home visits with the Psychiatrist on Fridays. The reviewers found two face-to-face member contacts by the CC for a total of 60 minutes in the last month in the ten member records reviewed. At the request of the reviewers, the CC provided a copy of his encounter log, which showed face-to-face member contacts accounted for about 12% of his time. However, it is difficult to extrapolate from this the actual time spent, as it appeared that time was recorded for billable contacts rather than actual time spent with members.	• The ACT CC should spend 50% of his time providing face-to-face member services. • The CC and the agency should identify any administrative functions not essential to the CC's time that could be performed by the program assistant or other administrative staff to free up time for direct member services, including shadowing and mentoring staff in delivery of community-based services.

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H5	Continuity of Staffing	1 – 5 1	The ACT team experienced a 96% turnover rate in 24 months (23 positions in 24 months), according to the data provided and clarification from staff interviews. Some positions, such as that of the SAS, Nurse and AS, remained vacant for several months, and others were filled rather quickly. Some positions turned over in less than a year. The record review noted two instances of temporary contracted Nurses. Staff interviewed reported that the high turnover may be attributed to agency expectations regarding billable contacts, documentation requirements, and time spent in travel across the county which may take away from focus on member care. One staff shared that some staff left due to feeling ineffective and frustrated with not seeing members making progress.	• The ACT team should maintain consistent staff over time for a turnover rate of no more than 20% in two years. Continuity of staffing is essential for promoting trust, therapeutic relationships, staff cohesion, and for maximizing the benefits of specialty training and other professional developments efforts. • The agency should identify contributing factors to high staff turnover and work to find solutions. Consider anonymous employee satisfaction surveys and exit interviews in order to gather and analyze feedback on why staff leave, as well as factors that promote retention.
H6	Staff Capacity	1 – 5 4	Data provided to the reviewers showed a per month sum total of 15 vacancies for a staffing capacity of 89.6%.	• Maintain staffing; see recommendation for item H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT Psychiatrist devotes 40 hours a week to the ACT team working a four, ten-hour days, Tuesday through Friday. He is the Chief Medical Officer at the clinic and staff said that the Psychiatrist spends half a day on Mondays seeing members of the supportive team. Staff reported that they do not believe that this hinders his availability to ACT staff or members, and that the Psychiatrist has an open door policy and also communicates well with them by email. Except for the Monday meeting, the Psychiatrist is at all the program meetings.	• Monitor the Psychiatrist's time spent with coverage on supportive to assure 40 hours is dedicated to the ACT team.
H8	Nurse on Team	1 – 5	At the time of the review the ACT team had at least one full-time Nurse1. It was unclear to the	• The agency should hire a second full-time Nurse into a permanent position.

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		3	reviewers if the second Nurse2 was still working on the team at the time of the review. While the CC reported that he was informed from the nursing supervisor that Nurse 2's last day would be the end of that week, some staff interviewed reported that she had left the team just prior to the review. The ACT team uses contracted Nurses who also serve other supportive teams at the clinic. Both Nurse1 and a contracted Nurse attended the morning meeting observed by the reviewers. Staff interviewed said that due to a nursing shortage at the clinic, Nurse1 also sees members on supportive teams from time to time. The reviewers did not see evidence in records reviewed that the nurses provide services in the community. However, Nurse1 volunteered to make a home visit to see a member during the meeting observed by the reviewers. Additionally, staff reported that Nurse1 is fairly new to the team and is starting to assist with medication observations in the community.	• The agency should ensure that nursing coverage from supportive teams does not interfere with the duties of other ACT Nurses who should be available to member needs at the clinic and in the community.
H9	Substance Abuse Specialist on Team	1 – 5 3	At the time of the review, the ACT team had one full-time SAS who has been serving in the position since 2013. Previous to the ACT team the SAS worked for five years for a private agency as a *co-occurring specialist*. The SAS demonstrates considerable knowledge and enthusiasm for the area of substance abuse treatment. He reported receiving additional training in the stages of change model and harm reduction from Terros. At the time of the review, the ACT team had just hired a second SAS whose start date was scheduled for mid-October. The CC did not have information on the specific training and	• The agency and the RBHA should ensure that future SASs who join the team have the necessary training and experience required to carry out the duties of the specialty, including providing cross training in the co-occurring model to other specialists on the team. • The agency and the RBHA should provide both SASs with ongoing training, education, and necessary clinical oversight in a stage-wise approach to substance abuse treatment.

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			experience of the newly hired SAS.	
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has an ES and an RS. The ES started on the team the week of the review. He was previously a Case Manager on a supportive team. Although the ES was not available for an interview, the CC said that he helped members find employment in his previous position. No information was provided on past training in vocational or employment services. The RS has been in her current position for 1.5 years, and reported that she previously worked as an RS on a supportive team. She said that she had participated in one rehabilitation training provided by the RBHA a year ago, and that she attends a quarterly meeting at Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR) that consists primarily of updates on policy, contact information, and new providers.	• The agency and the RBHA should provide the new ES and RS with on-going education, training, and mentoring required to help members find and sustain competitive employment, and to provide other ACT staff with cross training in vocational services.
H11	Program Size	1 – 5 5	The ACT team is of sufficient size to provide necessary staffing and diversity. The current team is comprised of the Clinical Coordinator (CC), the ACT Psychiatrist, two Nurses, a Substance Abuse Specialist (SAS), an Employment Specialist (ES), a Rehabilitation Specialist (RS), an Independent Living Specialist (ILS), a Housing Specialist (HS), and an ACT Specialist (AS).	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team follows the written admission criteria developed by the RBHA. The CC screens prospective members for appropriateness and explains the nature of services. Participation is voluntary so members are free to decline services. The CC discusses the member with the team and gives his recommendation on admission to the team Psychiatrist and the Clinical Director, who	• All ACT staff should be able to clearly articulate the ACT team's admission criteria.

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			makes the final decision. It was not clear to the reviewers that all staff interviewed could articulate the full scope of the admissions criteria. The CC reported no administrative pressure to accept members to the team.	
O2	Intake Rate	1 – 5 5	In the six months preceding the current review, the ACT team admitted no more than two members per month for a total of eight. There were no admissions in July; a single admission in August and September; and two admissions each in March, May, and June.	
O3	Full Responsibility for Treatment Services	1 – 5 3	Along with case management services, the ACT team is fully responsible for providing two other services: psychiatric and housing. Members only receive psychiatric services from the ACT Psychiatrist. Members whose housing needs require a staffed level of care are transferred to supportive teams. While the ACT team offers employment and other rehabilitative services they do not appear to be fully providing them at this time. A few members were identified as employed, but staff interviewed reported that caseload sizes had been high until recently due to chronic staff turnover, and that there was little available time to help members find jobs. Staff reported that one person is working with a job coach through an outside provider. It was not clear to the reviewers that the new ES has the background and training to provide this service. The ACT team seems poised to, but is not yet, fully responsible for providing substance abuse treatment. The SAS holds two well attended substance abuse groups each week. Although he	• The agency should ensure specialists receive education, training and mentoring to support cross-training for all staff, so that all services can be effectively provided by the ACT team. • Ensure that vocational specialists assist members with rapid access to competitive employment rather than referring to outside vocational services. Collaborate with Vocational Rehabilitation/Rehabilitation Services Administration (VR/RSA) to ensure employment needs are met. • The team should expand upon current substance abuse treatment to include individual substance abuse treatment without relying on outside providers. With proper clinical oversight, both the current and the incoming SAS should be able to provide this service on the team. • The team should provide individual supportive counseling psychotherapy (with the necessary clinical supervision and oversight) for members, and avoid reliance

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			demonstrates the knowledge, skill set and motivation to provide structured individual substance abuse counseling his workload appears to limit his ability to provide more than brief face-to-face engagements during home visits. Approximately six members are receiving substance abuse treatment services from outside providers. Staff interviewed said that the ACT team does not have staff credentialed to provide individual counseling psychotherapy. Those services are referred out, often to a licensed clinician within the agency, but that individual does not attend ACT program meetings.	on outside providers other than those who provide treatments outside the scope of staff expertise (i.e., EMDR, DBT).
O4	Responsibility for Crisis Services	1 – 5 3	The CC reported that the ACT team is available 24 hours a day to respond to crisis services. The team has staff on-call at all hours, with a Wednesday through Tuesday rotation; the CC is the back-up 24 hours as well. The team does not use "blue dot" or emergency calls routed through the clinic switchboard; calls instead go directly to staff. Staff have work cell phones; calls to their office phones are forwarded to their cell phones when they are out of the office. The CC provides office coverage for crisis when staff are out of the office. The CC was not certain if all members had the on-call phone number; however, he states that the members do have specialist cell phone numbers and do utilize them. CC reported that if members call the crisis line, the crisis line notifies the team and is first responder. Although the CC reported that ACT staff will go into the community when needed in response to crisis, staff said that most support is provided over	• The team should build trust and rapport with members and their informal supports, and educate them on how ACT staff can assist them in managing crisis situations. The team should have regular discussions with members regarding the benefits of allowing ACT staff to communicate with their informal support network. • Provide all members with printed emergency contact numbers for all specialists on the team. Updated contact information should be offered regularly to members and their informal supports. • Given that the team was involved in only 50% of the last ten psychiatric hospitalizations, the CC and the team should review their criteria for responding on-site to crisis calls and consider if any hospitalizations could have been avoided with face-to-face assessment and

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			the phone and that members usually wait until the next day to come into the clinic for follow up. One staff interviewed reported not having responded to crisis in the community in over six months.	intervention.
O5	Responsibility for Hospital Admissions	1 – 5 3	According to the CC, members are considered for psychiatric hospitalization if they are a danger to themselves or others, are not psychiatrically stable and presenting with psychotic symptoms and not taking their medications. The team tries to get them into the clinic to be assessed by the Psychiatrist. If the member agrees to a hospitalization, an ACT staff person takes him or her to the hospital and remains for the intake to ensure admission. If a family member contacts the team about a same day admission, a staff person meets the member at the hospital. If the member is unwilling to go to the hospital, and is under court ordered treatment (COT), the member is picked up by the police and transported; the team then tries to see the person within 24 hours. Per a review of data provided by the CC, the ACT team was involved in 50% of the last ten psychiatric admissions. The CC described a number of instances in which members sought psychiatric hospitalization on their own or when a family member admitted them and the ACT team was not alerted until some time after the admission. In one case the fire department transported a member to the hospital.	• The ACT team should be involved in all member hospitalizations. Provide ongoing education and reminders to members and their informal supports on the importance of involving the team in decisions to seek psychiatric hospitalization. • The CC should ensure all staff are aware of the team's role and process to assist with hospitalizations. • See recommendations for O4, Responsibility for Crisis Services.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The CC said that after hospital admission the ACT team stays in contact with hospital staff and attend all staff meetings to begin discharge planning. The CC said that ACT staff usually try and meet with the hospitalized member every 72 hours. The CC said that most hospitals keep in contact with the team and members are rarely	• Continue efforts to ensure 100% involvement in member hospital discharges.

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			discharged to the street. ACT staff are there to pick up the member when discharged. The CC said the member is scheduled to see the ACT Psychiatrist within 24 hours of discharge, and the team has daily contact with the member for five days after discharge. Per a review of the last ten psychiatric hospital discharges, the ACT team was involved in 90% of them. In the instance that the ACT team was not involved, the member was discharged to a family member who subsequently informed the team.	
O7	Time-unlimited Services	1 – 5 5	The CC said that in the last year two members graduated with significant improvement to a supportive team. He expects that four more members will graduate in the next 12 months. The ACT team uses the ACT EXIT Criteria Screening Tool, developed by the RBHA, to assist in evaluating a member's readiness for graduation or stepdown to a lower level of care. Members who graduate have demonstrated that they no longer need the intensity of ACT services, as evidenced by being stable in the community, maintaining employment, avoiding crisis and psychiatric hospitalization, and understanding their diagnosis. Graduating members are oriented to what they can expect on a supportive team and feel capable of managing with the reduced contact. Members can, however, choose to remain on the team if they feel it is essential to their recovery.	
S1	Community-based Services	1 – 5 4	Staff interviewed estimated that 75% - 80% of member services are community-based, rather than office-based. A review of ten randomly selected member records found that the ACT team delivered 60% of services in the community for the period reviewed. Staff said travel time and the	• Focus on timely documentation to accurately reflect member engagements. • Rather than encouraging members to come to the clinic, staff should focus on providing services in the community, where staff can

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			pressure to attain encounter expectations and complete documentation remains an obstacle. Staff said improvements in agency provided technology and zoned coverage has made community-based delivery of services easier. Most community contact occurred in members' homes, reflecting medication observations and assessment of living environment. Many records showed contact of 20 – 40 minute home visits but few reflected meaningful engagement in skill building activities or other recovery oriented goals.	more effectively assess, monitor, and assist members with problem solving and skill building, with a goal of providing 80% of contacts in the community. • Avoid implementation of site-based groups not specifically referred to in the evidenced-based ACT protocol.
S2	No Drop-out Policy	1 – 5 4	According to the data provided and the CC interview, the ACT team achieved a member retention rate of 92% for the period under review. Five members refused services, one person requested a step down to a lower level of care, and one member left the geographical area without first alerting the team. The CC said that some of the members that refused services had not been with the team very long and had refused services after court ordered treatment expired. The CC said that when notified in advance that members plan to leave the community the ACT team will offer to set up behavioral health services in the person's new location. The CC said he is trying to find out the new location of the member who recently left the state in order to offer assistance with continued services in the member's new community. The CC did not think that the ACT team could have done anything more than their outreach and engagement efforts to keep the members on the team.	• Stabilize staffing to reduce turnover, which may improve therapeutic rapport between staff and members, as well as rapport with member informal supports. • Training for all staff in motivational interviewing (MI) may support staff efforts to establish therapeutic rapport with members. Using MI techniques can help members create individualized, strengths based, recovery oriented service plans to achieve personally meaningful goals thus increasing internal motivation for change. • See Recommendation for S3, Assertive Engagement Mechanisms.
S3	Assertive Engagement Mechanisms	1 – 5 4	The ACT team uses an Eight-Week Outreach Engagement Strategy to keep members involved in the team. The CC said when members miss	• Assertive engagements makes use of street outreach activities such as visiting locations

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			appointments or appear to have dropped out of sight that the team makes contact using phone calls; home visits; outreach to guardians, probation officers, and payees; and check-ins with jails, hospitals, and Central Arizona Shelter Services (CASS). Reviewers observed discussion in the morning meeting of the team using text messaging and coordination of payees to facilitate outreach. Additionally, the reviewers found evidence in some charts of phone calls to payees and guardians to locate members but no evidence of street outreach or plans for locating members.	where members are known to spend time and making direct contact with informal support networks including faith-based organizations, employers, and friends. Some ACT teams also utilize technologies such as text and social media to make contact with hard-to-reach members.
S4	Intensity of Services	1 – 5 2	Per the review of ten randomly selected member records, members received an average of 29 minutes of service per week. Individual averages across all ten records ranged from a low of 19.5 minutes to a high of 103 minutes. The reviewers found many examples of case notes that lacked meaningful content related to person-centered goals, staff interventions, or follow up actions for time spent, but instead merely report of member presentation and condition of the living environment.	• The ACT team should provide members an average of two hours of face-to-face contact each week. Intensity may vary based on the member's stage of recovery, but an average of two hours across the team should be the goal. Contacts should be person-centered, based on needs, and delivered in the community to best promote skill building and new knowledge. (See recommendation for item S1, Community-based Services).
S5	Frequency of Contact	1 – 5 2	Per the record review, members received an average of one staff contact per week. Across ten records, individual averages ranged from .75 to 4.5 contacts per week.	• The ACT team should provide members with an average of 4 contacts per week. Contacts should be purposeful, person-centered, and recovery oriented. (See recommendations for items S1, Community-based Services, and S4, Intensity of Services).
S6	Work with Support System	1 – 5 2	The CC said that out of 93 members approximately 50 have an informal support that the team has been in contact with at least once in any given month. Other staff interviewed estimated that 80% of ACT members have an informal support	• With the goal of having four or more contacts per month with informal supports, ACT staff should regularly talk with members about the benefits of allowing staff to have contact with informal

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			system. One staff member said that staff had at least one contact with each support every month, while another said that some informal supports do not want to be involved. Per the record review, members' informal supports received 1.20 contacts with staff per month. Across ten records, individual contacts ranged from a low of zero (five records) to a high of five contacts. During the observed program meeting, the reviewers counted two mentions of staff contact with members' informal supports.	supports; obtain current Release of Information/ Authorization to Use and Disclose (ROI/AUD) forms and provide regular outreach to support the spirit of collaboration/cooperation. • Staff should regularly check in with informal supports where appropriate to encourage their role as allies in recovery; to provide useful psychoeducation about symptoms and behaviors; and to obtain their feedback on members' functioning/needs/progress. • The CC should clarify with staff the parameters surrounding documentation of information provided by informal supports, and its relationship towards fidelity in this area.
S7	Individualized Substance Abuse Treatment	1 – 5 3	The SAS reported that of the 93 members on the team, 51 are diagnosed with a co-occurring disorder (COD). The SAS said that he sees 15 members for individual substance abuse counseling for 15 – 20 minutes each week (approximately four minutes a week calculated across all members with a COD). Rather than formerly scheduling sessions, he incorporates the counseling into scheduled home visits, allotting time after the home assessment for substance abuse counseling. He said he uses a cognitive behavioral approach along with the harm reduction philosophy. He expects to be able to increase time spent after the second SAS joins the team in mid-October 2016. Although the reviewers found many instances in the record review of the SAS offering to engage	• The current, and the incoming, SAS should provide an average of at least 24 minutes of individual substance abuse treatment across all members diagnosed with a COD. Sessions should be scheduled and formally structured using a stage-wise treatment approach. SASs should have the necessary clinical oversight to allow for this service to be provided by the team. • Consider organizing SAS schedules around the needs of members diagnosed with a COD and their level of treatment. For example, members in engagement, persuasion, or active treatment may work with an SAS while those in relapse prevention stage may be appropriately transferred to a staff whose specialty fits current needs or goals identified on the

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			members in substance abuse discussions, they saw no evidence of formal, individualized substance abuse treatment.	member's service plan, such as finding a job, returning to school, or finding housing to fulfill family reunification goals. • Ensure timely documentation of all substance abuse engagement efforts and treatment in member records.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SAS facilitates two substance abuse groups each week (approximately eight sessions per month on Tuesdays and Fridays) that are well attended, averaging 12 members per group. The SAS attributes the good attendance to direct face-to-face outreach. When notified by other staff that a member shows signs of using, the SAS makes a personal invitation to the members, reassuring the member that he or she can observe the group and then decide whether or not to become involved. The SAS said that he uses an integrated model, mixing CBT, psychoeducation of the effects of substance abuse on the brain and their physical health, skill building to help them deal with feelings and emotions, and relapse prevention. Although previously skeptical of the harm reduction approach, he said he now embraces it after training offered by the agency and RBHA. The SAS described pulling group content from a variety of sources such as the RBHA, another provider clinic, and resources he finds doing on-line research to address member needs. Evidence was found in the record review of co-occurring groups.	• Continue outreach and engagement efforts to increase substance abuse group participation in members diagnosed with a COD. • With the start of a second SAS consider the feasibility of adding substance abuse groups specific to COD diagnosed members with diverse cultural or emotional safety concerns, such as Spanish speaking, women, young adults, or LGBT who have not yet engaged in substance abuse treatment services.
S9	Co-occurring Disorders (Dual	1 – 5	The SAS described using an integrated approach that respects each member's readiness for change,	• The agency and RBHA should provide education and training to all ACT staff on a

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	Disorders) Model	3	that encourages small steps toward reducing use, and avoids using pressure to abstain or shaming in response to relapse. As reported in the previous item, the SAS said that he took several trainings to understand the harm reduction approach but exposure and witnessing its results convinced him of its utility. He reported recent trainings at the clinic and for SASs. The SAS views AA as helpful for some people in "exposing them to another setting with people who are making changes". He said the team also refers members to detox when they exhibit significant physical withdrawal symptoms. The SAS appears to have the knowledge and motivation to provide effective cross-training on the ACT team in the co-occurring approach. However, the team culture, most of whose staff are new to both the ACT team and the ACT model, appears to still be rooted in more traditional approaches. The reviewers noted an absence of language reflecting broad understanding across the team of the dual diagnosis model and stage-wise treatment approach. For example, discussion lacked a recovery orientation whereby member strengths and personally meaningful goals could be used to motivate movement from pre-contemplation and contemplation stages to preparation and latter stages of change.	dual disorder model, such as Integrated Treatment for Co-Occurring Disorder, the stage-wise treatment approach, and motivational interviewing. Training should be ongoing to accommodate for new and less experienced staff. Standardizing a basic tenant of treatment may help ensure consistent interventions across the system. • The CC, the ACT Psychiatrist, and the SAS should collaborate to ensure that program meetings have a support the COD model.
S10	Role of Consumers on Treatment Team	1 – 5 1	The time of the review, the ACT team did not have a Peer Support Specialist on staff.	• Hire a qualified PSS for the ACT team to provide a voice and perspective of lived experience of disability and recovery to member services.
	Total Score:	**3.43**		

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	1
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	3
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	3
5. Responsibility for Hospital Admissions	1-5	3

	Rating Range	Score (1-5)
6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	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	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	1
Total Score	**3.43**	
Highest Possible Score	**5**	