ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: December 7, 2023

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AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with Western Interstate Commission for Higher Education Behavioral Health Program to conduct Fidelity Reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an evidence-based practice (EBP).

Method

On November 6 – 8, 2023, Fidelity Reviewers completed a review of the Copa Health West Valley 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 the Central Region of Arizona.

Copa Health operates several outpatient centers that offer a variety of services, such as integrated healthcare, employment related services, day program activities, and residential services. Individuals served through the agency are referred to as members.

The SAMHSA ACT Fidelity Review tool does not accommodate the delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to observe meetings, and to interview staff and members.

During the fidelity review, reviewers participated in the following activities:

- Remote observation of an ACT team program meeting on November 7, 2023.
- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with Housing, Employment, ACT, and Peer Support Specialists, and an agency staff providing counseling services to ACT members.

- Group video conference interview with the teams Co-Occurring Specialists.
- Individual phone interviews with five (5) members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator and representative from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; resumes and training records for the Employment Specialist and Co-Occurring Specialists' staff; Clinical Coordinator productivity report; 8-week Outreach Workflow; *Natural Support Tracking Tool*; *Welcome to Assertive Community Treatment (ACT)* handout; copies of cover pages of co-occurring disorder treatment material; and member calendars.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a 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 with little room for improvement*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team's approach has improved noticeably. 90% of members have interaction with multiple staff members in a two-week period; team personnel are familiar with all members and share responsibility for each member.
- The Clinical Coordinator excels at providing direct in-person services to members of the team.
- The team has a Psychiatric Nurse Practitioner (Prescriber), and two Nurses fully dedicated to work with the 97 members of the team.
- Through assertive engagement practices and procedures, the team retained nearly 100% of the ACT members.

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

- The team experienced a staff turnover rate of 79% during the past two years. Identify factors that contributed to staff turnover and implement a protocol that supports retention.
- Increase in-person contacts in the community directly supporting members. ACT services are best provided in the community where challenges are more likely to occur and where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.
- Increase support for members that receive a lower intensity and frequency of service. ACT teams provide members with an average of two (2) or more hours of in-person service delivery weekly and an average of four (4) or more in-person contacts weekly.
- Provide ongoing training to all staff in an evidence-based practice for members with a co-occurring disorder diagnosis.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 - 5 4	The ACT team serves 97 members with nine full-time equivalent (FTE) direct service staff, excluding the Prescriber and administrative staff. The team has a member to staff ratio of approximately 11:1. Staff on the team include the Clinical Coordinator (CC), Peer Support Specialist, Housing Specialist, Employment Specialist, ACT Specialist, two Nurses, and two Co-Occurring Specialists (COS).	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 - 5 5	Staff report having an assigned caseload that includes responsibilities of administrative paperwork, and seeing members on their caseload once a week, in addition to seeing geographically assigned members that rotate on a weekly basis. Staff schedules are staggered so that weekends are covered to ensure members have access to staff. All members interviewed reported seeing multiple staff from the team every week, either at the clinic or in the community. Records reviewed for a month period, show a median of 90% of members received in-person contact from more than one staff from the team in a two-week period.	• Consider eliminating assigned caseloads. The team approach ensures continuity of care for members and creates a supportive environment for staff, potentially reducing the burden of responsibility. ACT staff are cross trained to work as a transdisciplinary team rather than individual case managers. Further, ACT team staff collaborate on assessments, treatment planning, and day-to-day interventions.
H3	Program Meeting	1 - 5	The team meets four days a week in person to review all members on the roster. All staff are	

		5	expected to attend on the days scheduled to work, including the Prescriber. During the meeting observed, staff provided input on recent members and natural support interactions, including attempts and planned contact for the week. Staff identified members' attendance to appointments and groups. Outreach assignments and tactics for engagement were discussed, as well as the stage of change for members identified with co-occurring disorder diagnosis.	
H4	Practicing ACT Leader	1 - 5 5	Based on the CC's productivity report for a four-week period, the CC provided direct services 63% of the time expected of other ACT staff. Reported activities include home visits, facilitating groups at the clinic and in the community, reviewing treatment goals with members, meeting with members at the clinic before or after groups, and attending member appointments with the Prescriber or Nurses. Of records reviewed, there were examples of the CC delivering in-person services at the clinic and in the community in four records. There were three additional charts in which documentation indicated the CC also made phone calls to members, members' natural supports, and coordinated services with other service providers. *The fidelity tool does not accommodate delivery of telehealth services. This item is dependent on the Provider productivity expectation.*	

H5	Continuity of Staffing	1 - 5 2	Based on the information provided, the team experienced a turnover rate of 79% during the past two years. Nineteen (19) staff left the team during this time. The position with the most turnover was the Nurse.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff. • If not done so already, consider examining employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention.
H6	Staff Capacity	1 - 5 3	In the past 12 months, the team operated at approximately 77% of full staffing capacity. The Independent Living Specialist position has been vacant for 12 months.	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible with the goal of operating at 95%, or more, of full staffing annually. Timely filling of vacant positions also helps to reduce the potential burden on staff.
H7	Psychiatrist on Team	1 - 5 5	The team has one FTE Prescriber that works four, ten-hour days Monday through Thursday. Staff interviewed reported that the Prescriber provides services to members in-person at the clinic, by telehealth (videoconference), and in the community. The Prescriber is accessible to the team in person, by phone, and email. Staff reported the Prescriber is available to the team after hours and weekends. When coordination is required after hours or on weekends, the CC will normally assume responsibility on behalf of the staff. The Prescriber only sees members that are on the ACT team and has no other responsibilities outside of the ACT team. Members interviewed all reported meeting the team Prescriber at least once a month in person at	

			the clinic, and one member reported the Prescriber came to their home. Per records, the Prescriber provided direct service to eight members in the month period reviewed. These services were provided in person at the clinic and by videoconference.	
H8	Nurse on Team	1 - 5 5	The team has two Nurses assigned to work with the members of the team. The Nurses' schedules are staggered, attending the program meeting on days assigned to work. Nurses are available to the team after hours and weekends. The Nurses are assigned one day a week to provide services to members in the community. Per review of records, the Nurses provided direct service to nine members in the month reviewed, both in-person at the clinic, and in the community.	
H9	Co-Occurring Disorder Specialist on Team	1 - 5 4	The team is staffed with two COSs. One COS recently joined the team in July 2023, and per an interview with staff, has some experience providing groups and individual treatment to individuals with a substance use disorder. Training records provided showed the COS completing *The Illness Management and Recovery Model* and *Motivational Interviewing* through *Relias* since onboarding with the team. The second COS, a Licensed Associate Substance Abuse Counselor, has been on the team since 2016, and receives weekly supervision by a Licensed Professional Counselor. Per training records provided, and since the last review, the COS lacks evidence of recent training related to treating co-occurring disorders.	• Provide annual training to Co-Occurring Specialists in co-occurring disorder treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing.* On ACT teams, COS have the capability to cross-train other staff, providing guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorder model utilized by the team.

			Both COS staff attend weekly group supervision by a Licensed Professional Counselor.	
H10	Vocational Specialist on Team	1 - 5 2	The team has one Vocational Specialist providing services to members. The Employment Specialist has been working with members on this team since April 2023. Per resume and staff interviews, the Employment Specialist does not have previous experience supporting individuals finding employment in an integrated setting. Based on training records provided, the Employment Specialist completed one, two-hour employment-related training since onboarding the team. Staff reported the Employment Specialist has not attended regional training or support meetings provided by contractor with a Regional Behavioral Health Agreement.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Ensure Vocational Staff receive annual training in assisting people diagnosed with a serious mental illness (SMI) to find and retain employment in integrated work settings. • Support Vocational Specialist staff to attend quarterly vocational meetings available through the Regional Behavioral Health Agreement to keep current on available resources.
H11	Program Size	1 - 5 5	At the time of the review, the team was composed of ten (10) staff including the Prescriber. The team is of sufficient size to provide staffing diversity and coverage to members of the team. There were two vacant positions: the Rehabilitation Specialist and the Independent Living Specialist. *This item does not adjust for the size of the client/member roster.*	
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. New referrals are received from the local contractor with a Regional Behavioral Health Agreement, hospitals, *Crisis Response Network*, other teams within the agency, and other provider network organizations. The CC is primarily responsible for screening potential members. As a backup screener another	

			staff that is also trained. New ACT team staff sit in screenings to observe the process. After completion of the screening, the CC will staff the potential member with the Prescriber. The Prescriber will review documentation, coordinate with the referring doctor, and, when needed, conduct a staffing with the member's current clinical team and the ACT team. The Prescriber has the final determination for new admissions to the team. Staff reported that recently some referred members believed that they had to accept ACT services in order to be discharged from the inpatient setting. Staff refute this by informing that ACT is entirely voluntary.	
O2	Intake Rate	1 - 5 5	Per data provided, the team has an appropriate rate of admission. The month with the highest rate of admission was August, with five (5) new members added to the ACT team roster.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management services, the team directly provides psychiatric services and medication management, housing support, and co-occurring disorder treatment. All members are served by this team's Prescriber for medication management. Based on interviews with staff, of the 97 members, the team has 2 – 9 members that reside in staffed locations, resulting in less than 10% receiving duplicated services from staff at their residence.	• Counseling/psychotherapy is made available to members on ACT teams and is provided by ACT staff. That position will also act as a generalist within the team. Consider options to include staff on the team that are qualified to provide individual counseling to members. • Ensure Vocational Specialist staff receive supervision and training so that they can directly assist members to find and keep jobs in integrated work settings rather than relying on vendors. • Support Vocational Specialist staff to provide cross training on the benefits of

			The team has two COSs to provide both individual and group substance use treatment services to members with a co-occurring disorder. Counseling/psychotherapy is not provided by the team. An agency Licensed Associate Counselor is assigned one day a week to provide one-to-one therapy for members of this team. Staff estimated seven to nine members meet regularly with the provider. Staff reported 13 members are currently working, and the team is providing employment support for all by checking in with the members one to two times monthly about their employment. One staff reported that when members need additional assistance maintaining employment, a referral to a brokered agency for a job coach may be completed. Two members are receiving services from a Work Adjustment Training Program (WAT). The team is supporting 3 – 4 members in job search efforts, including searching for job opportunities near member residences, transporting and assisting members with interviews, assisting with obtaining a phone and other tools to support members with employment. During the program meeting, the team discussed employment related needs, engagement, and updates for nine members. Records reviewed showed staff, including the Prescriber, encouraging employment with members.	competitive employment versus other sheltered services (e.g., WAT).
O4	Responsibility for Crisis Services	1 - 5	Based on interviews, the ACT team is available to provide crisis services 24 hours a day, seven days a week. Staff rotate on-call responsibilities weekly, the CC is the back up. Staff provided a copy of the	

		5	*Welcome to Assertive Community Treatment (ACT)* handout given to members and natural supports that includes general information about ACT services the team provides. In addition, the handout lists the main West Valley Campus contact number, ACT team meeting times, ACT team on-call number, and the contact numbers for each specialist position. All members interviewed were aware of the ACT on-call line and reported using it. Records reviewed showed staff supporting members after hours by phone.	
O5	Responsibility for Hospital Admissions	1 - 5 3	Staff reported that when members are experiencing an increase in symptoms during business hours, the team requests that the member be assessed for the need for hospitalization by the Prescriber or Nurse. When members decline the invitation, the team evaluates them in the community and consults the CC, who then coordinates with the Prescriber for next steps. Members will be driven to the inpatient unit by staff and will stay with the members until they are admitted. In the event the team needs to utilize law enforcement to transport the member, staff will follow the patrol vehicle to the hospital. When a member is experiencing increased symptoms after business hours, the team attempts to de-escalate the situation over the phone or will meet with the member in the community and will consult the CC for next steps. The ACT Prescriber coordinates with the inpatient treating provider after the member is admitted. The team accesses	• ACT teams performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. • Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can provide aid during admission, especially for members with a history of seeking hospitalization without team support.

			the agency electronic health record via phone to provide information about the member to inpatient teams. Per the review of data from the ten most recent psychiatric hospital admissions, occurring over a two-month period, the team was directly involved in 40% of the admissions. For admissions the team was not directly involved, members self-admitted without the team's knowledge. Coordination of care with the inpatient team commenced upon notification to the ACT team.	
O6	Responsibility for Hospital Discharge Planning	1 - 5 4	Per staff reports, discharge planning begins as soon as a member is admitted or when the team is notified of an admission. Staff will coordinate with guardians, advocates, and natural supports for discharge planning and include them in inpatient staffing's. Staffing is conducted in-person, by phone, or via videoconference within 72 hours of admission and continues weekly until discharge. The team rotates hospital visit assignments among staff and completes visits with members on Monday, Wednesday, and Friday. Upon discharge, the team meets with members at the inpatient unit, gathers discharge paperwork, and ensures medications are called into the preferred pharmacy. Members are typically transported to the clinic to meet with the Prescriber on the same day as discharge. Members are scheduled with the Nurse the following day; in addition, the team follows a five-day in-person follow-up protocol.	• To ensure the team is directly involved in 95% or more of psychiatric discharges, continue to build relationships with inpatient treatment teams and use resources available to advocate for member care. Some teams create business cards with team information that members can carry on their person to reference when interacting with other agencies/providers and expedite coordination of care.

			Per the review of data with staff relating to the last ten psychiatric hospital discharges, which occurred during a two-month period, the team was directly involved in 90%. One member was discharged by the inpatient team with a bus pass despite concerted efforts of coordination.	
O7	Time-unlimited Services	1 - 5 4	Data provided indicated the team graduated six (6) members in the past 12 months. Staff reported another 5% of members are on target for graduating in the next year.	• Since ACT teams traditionally serve those with the most complex behavioral health issues and those that have been unsuccessful in traditional outpatient teams, the ACT team should strive to graduate fewer than 5% of membership annually.
S1	Community-based Services	1 - 5 3	Staff interviewed reported 80 - 90% of in-person contacts with members occur in the community. Examples of services delivered in the community included independent living skills, medication education and observation, annual paperwork completion, housing, and employment support. Members interviewed reported varied responses as to how often the team provides services to them in the community versus at the clinic. The results of ten randomly selected member records reviewed show staff provided services a median of 58% of the time in the community. All ten records had documentation of staff delivering services in the community; two members received 100% of the services provided by the team in the community.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting. • Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts. Evaluate which clinic-based activities can transition to occur in the community.
S2	No Drop-out Policy	1 - 5	According to data provided and reviewed with staff, the team had six members that left the ACT program in the past year, for a retention rate of nearly 100%.	

		5		
S3	Assertive Engagement Mechanisms	1 - 5 5	According to staff, when a member is unable to be located or misses an appointment, staff will complete three to four outreach attempts each week, minimally for eight weeks. At least two attempts are completed in the community, and the other two consist of electronic outreach such as phone calls and emails. The team's approach to outreach and engagement efforts includes going to the member's last known address, locations in the community where the member is known to frequent and searching around local homeless shelter grounds. The team will contact natural supports, guardians and advocates, hospitals, the medical examiner's office, pharmacies, payees, and probation officers. Of the records reviewed, no members were on outreach as the team was successful at engaging all members in services. Outreach assignments are rotated among staff weekly for disengaged members. Reviewers were provided with the *8-week Outreach Workflow* and witnessed staff updating the team on outreach attempts, including specific areas in the community to search, during the program meeting observed. In the event the team cannot locate a member in eight weeks, the member will be transferred to *Navigator* status. Although not all members move to *Navigator* status. The team reported one example of a member's guardian being insistent that the member continue to remain on the member roster even though the member has expressed a desire to discharge from the team.	

			The team has been unable to engage the member in services. Staff reported feeling pressure from the contractor with a Regional Behavioral Health Agreement to keep the member on the team roster.	
S4	Intensity of Services	1 - 5 2	Per review of records, during a month period prior to the fidelity review, the median amount of time the team spent in-person with members per week was 45 minutes. The highest rate of intensity averaged 122 minutes a week, and the lowest indicated a rate of intensity of 16.25 minutes a week. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the duration of service delivery to members. ACT teams provide an average of two (2) or more hours of in-person services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms. • Ensure the team is assisting members in working on recovery goals as identified. By using motivational interviewing, and other techniques, the team can assist members to identify meaningful recovery goals and then offer the supports and services to members to reach those goals.
S5	Frequency of Contact	1 - 5 3	Of the ten records randomly sampled, ACT staff provided a median frequency of 2.25 in-person contacts to members per week. The member record with the highest frequency of contact was 3.75 contacts per week and the member record with the lowest frequency of contact was 0.75 contacts per week. Nine of the ten member records reviewed had phone contact documented by the team.	• Increase the frequency of contact with members by ACT staff, preferably averaging four (4) or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have different needs/goals and frequency should be determined by those needs and immediacy.

			All members interviewed reported meeting with at least one ACT staff person per week.	
S6	Work with Support System	1 - 5 4	Data provided indicates that 41 members have natural support. Staff reported contact with natural supports varies based on the member. The team attempts to contact natural supports at least twice a month whether that is in-person, by phone, or email. The team tracks natural support contact during the program meeting and provided reviewers with their *Natural Support Tracking Tool* for the previous month. Based on that document, 19 members' natural supports were contacted; six of those members' natural supports were contacted four or more times. Two member records reviewed were those identified by the team with natural support. A total of four charts documented natural support contact by the team, ranging from 1 – 5 contacts per member for the month period reviewed. During the program meeting, the team discussed contact with natural supports for 21 members. Members interviewed reported varied responses of contact with their natural supports. One member reported daily contact, two members reported contact once a week, another reported bi-monthly contact, and one member reported not having any natural supports for the team to be in contact with.	• Assist members in developing a natural, community-based support system. Active participation with peer run programs are a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact. • Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four (4) per month for each member with a support system.
S7	Individualized Co-Occurring Disorder Treatment	1 - 5 3	Based on data provided and reviewed with staff, 43 members on the team have been identified as having a co-occurring disorder. Staff indicated 10 - 15 of those members receive formal structured individual co-occurring treatment sessions,	• Work to provide an average of 24 minutes, or more, per week of structured individualized substance use treatment services for all members with a co-occurring disorder diagnosis.

			averaging one to two times per month and ranging from 30 – 35 minutes per session. Staff indicated offering treatment sessions to members with a co-occurring disorder, but members decline. During the program meeting, staff discussed member engagement with COS staff for co-occurring treatment, and the stage of change was identified for members with a co-occurring diagnosis. Materials used to provide treatment to members with a co-occurring disorder are the *Integrated Dual Diagnosis Treatment* (IDDT), and the *Recovery Life Skills Program* manuals. The COS staff utilize the *University of Rhode Island Change Assessment* (URICA) every three to six months minimally to identify stages of change for members. Staff reported using clinical judgment when providing treatment relating to the stages of change. Based on record review, seven members were identified by the team with a co-occurring disorder diagnosis; one additional record had a documented co-occurring disorder but not identified by the team. One individual 25-minute treatment session was documented. The session focused on harm reduction and recovery-based strategies. Staff indicated the team does not use a system to track structured individual counseling sessions delivered or the duration of those sessions.	• Document the offering of services and the delivery of individual treatment to members with co-occurring disorder diagnoses. Consider providing training to staff on strategies to engage members in individualized treatment, as appropriate, based on members' stage of change. • Evaluate if COS participation in other duties, such as medication observation, limits the ability to engage or provide individual substance use treatment. Consider shifting those duties to other staff if indicated. • Consider developing a method of tracking member co-occurring disorder treatment participation, duration, and frequency to improve monitoring of services provided.
S8	Co-Occurring Disorder Treatment Groups	1 - 5	Staff reported that one co-occurring disorder treatment group from the team is available to members weekly. Occasionally, an additional group is scheduled on Fridays. The group is	• Optimally, 50% or more of members with a substance use disorder diagnosis attend at least one co-occurring disorder treatment group each month. On ACT teams, all staff

		2	facilitated by the licensed COS. All members of the team are welcome to join the co-occurring treatment groups, rather than specifically being focused for members with a co-occurring disorder diagnosis. According to sign-in sheets for the month prior to the review, seven (16%) of members with a co-occurring disorder diagnosis attended at least one co-occurring treatment group. Record review showed one of the eight members with a co-occurring disorder diagnosis attended one group in the month period reviewed.	engage members with a co-occurring disorder diagnosis to participate in treatment groups, based on their stage of change, with content reflecting stage-wise treatment approaches. • Evaluate the benefit of offering groups specifically for members with co-occurring disorder diagnoses. There may be overlapping areas discussed in similar groups for members without co-occurring disorder diagnoses, but ideally co-occurring treatment groups are designed to provide members with a safe space to address recovery efforts with peers.
S9	Co-Occurring Disorders Model	1 - 5 3	Staff reported utilizing a harm reduction approach when working with members with a co-occurring disorder diagnosis and provided examples of tactics and interventions used. When members request detoxification services, the team will refer them to local resources as medically necessary. When a member requests information on peer-run support groups in the community, staff will support. During observation of the program meeting, not all staff used accepting and non-judgmental language. When identifying specific concerns of member use, the team missed opportunities to discuss engaging those members in stage-wise approaches. Record review for one member indicated the member requested assistance for substance use treatment; an appointment was offered and scheduled with the Prescriber to be addressed.	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as Integrated Co-Occurring Disorders Treatment, in the principles of a stage-wise approach to interventions, the EBP of harm reduction, and motivational interviewing. With staff turnover, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Identifying a co-occurring disorder treatment model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in recovery. • Ensure ACT staff understand the value of utilizing a stage-wise approach when engaging members with a co-occurring disorder. Team interventions would then align with individuals' current stages and

			Records did not show documentation of that appointment, or engagement with COS. Records showed a variety of staff encouraging members to participate in groups with the team but did not specify if it was substance use related. One showed the Prescriber encouraging the member to engage in individual and group substance use treatment. Of the eight member records that had a co-occurring disorder diagnosis, five had treatment plans that identified substance use goals with a primary focus on frequency of service delivery, rather than interventions the team will use to support members to reach their recovery goal. Another member's chart reviewed in the random sample indicated a co-occurring treatment goal but did not have a documented co-occurring diagnosis. Treatment plans are not written in the member's voice. Staff report training by COS staff on co-occurring treatment principles occurs once every couple of months. COS staff are available to the team on an individual basis to ACT staff requesting education and direction when working with members with a co-occurring disorder. All staff interviewed reported completing training in *Relias* related to co-occurring disorders.	thus be more likely to be accepted by the member. • Ensure treatment plans are written from the member's point of view, recovery focused, and outlines steps the team will take to address substance use while supporting the member in recovery.

S10	Role of Consumers on Treatment Team	1 - 5 5	The team has at least one staff with lived or living psychiatric experience who shares their story with members and team. Staff interviewed reported that the staff's perspective as a peer allows the team to have greater insight into the needs of members. Three of the five members interviewed had knowledge of staff with personal lived or living psychiatric experience and expressed gratitude and value the positive impact on the services they receive.	
Total Score:		**110**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	5
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	5
9. Co-Occurring Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	2
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	3
6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	4

Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
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	3
6. Work with Support System	1-5	4
7. Individualized Co-Occurring Disorder 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	**3.93**	
Highest Possible Score	**5**	