ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 13, 2017

To: Peggy Chase, Chief Executive Officer
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From: Georgia Harris, MAEd
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AHCCCS Fidelity Reviewers

Method

On October 12 – 13, 2017, Georgia Harris and Karen Voyer-Caravona completed a review of the Terros 51st Avenue Recovery 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 ACT team is operated by Terros, a comprehensive healthcare organization. Founded in 1969, Terros is known for its expertise in mental illness and co-occurring disorders; their services seek to integrate behavioral health and primary medical care. Formerly known as the West McDowell ACT team during previous review periods, the ACT team relocated in the last year from the corner of 51st Ave and West McDowell to its present location at 4316 N. 51st Ave and the new 51st Avenue Recovery Center. The new clinic office is a comfortable shared workspace, which the Clinical Coordinator described as conducive to encouraging delivery of community-based services. Most staff interviewed expressed appreciation for the new offices. During the course of the review, staff informed the reviewers that the clinic participates in the agency's *behavioral health university* model, which emphasizes psychoeducation, skill-building, and activity groups, reframed as classes, delivered at the clinics. ACT members are not restricted from participation in these classes, and there was evidence of their participation throughout the review.
The individuals served through the agency are referred to as *clients* and *members*, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

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

- Observation of a daily ACT team meeting;
- Individual interview with team leader/Clinical Coordinator (CC);
- Individual interviews with ACT Counselor (AC) and Rehabilitation Specialist (RS);
- Group interview with the Housing Specialist (HS) and the Peer Support Specialist (PSS);
- Group interview with five members receiving ACT services;
- Review of ten randomly selected ACT member records using the agency's electronic medical records system; and
- Review of agency provided documents including: Resumes for the AC, RS, and ES; the CC's encounter report; the AC's log of individual

contacts, COD sign-in sheets; the 51st Ave ACT Team Welcome Letter, list of staff contact numbers, and Client and Natural Supports Surveys; RBHA developed *ACT Eligibility Screening Tool* and *ACT Exit Criteria Screening Tool*; *ACT Team Morning Meeting* notes, and *8-Week Outreach Engagement (T-XIX)* strategy.

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:

- Program meeting: The ACT team conducts four program meetings each week where all members' status, including emerging needs and information derived from informal supports, are discussed.
- Explicit admission criteria: The ACT team uses the RBHA *ACT Eligibility Screening Tool* to guide all admissions; all staff interviewed were able to articulate the admission criteria. The team reports no external pressure to accept members who do not meet the criteria.
- Intake rate: The team takes new members at a slow rate to maintain a stable, consistent service environment. For the six months prior to the review, the ACT team admitted 16 new members, with a range of 1 – 6 members per month between April and September.

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

- Practicing team leader: Per records provided to the reviewers, for a 30-day period prior to the review, less than 10% of the CC's time was spent providing face-to-face services to ACT members. The team and the agency should explore solutions to identified barriers to the CC achieving 50% of the time providing direct member services, preferably in the community.
- Substance abuse specialist on team: Two positions share substance abuse treatment responsibilities on the ACT team, the Substance Abuse Specialist and the ACT Counselor. Though the AC provides individual and group substance abuse treatment (in the role of SAS) and demonstrated impressive knowledge in the Co-occurring Disorders model, the position of the Substance Abuse Specialist was unfilled at the time of the review. The agency should hire and retain an experienced SAS to ensure that the 100 member team has two qualified clinicians dedicated to providing substance abuse treatment.
- Community-based services: Per a review of ten-member records, ACT staff provide face-to-face services in the community 35% of the time. The ACT team and the agency should brainstorm ideas to eliminate barriers to providing services in the community, with a goal of 80% of the time, including ways to facilitate timely documentation of contacts in the field.
- Co-occurring model: Knowledge of the dual disorders model varied greatly among staff, ranging from "none at all" to "knowledgeable and practicing". The agency should prioritize on-going training and education for all ACT direct service staff in the dual disorders principles, including continued cross-training and clinical consultation by the well-educated ACT Counselor.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	According to the CC, the ACT team has 12 positions. At the time of the review, two positions, one SAS and the Independent Living Specialist (ILS) were open. Excluding the ACT Psychiatrist, nine staff served 100 ACT members, for a member/staff ratio of 11:1.	• Fill vacant positions and maintain a member/staff ratio of no more than 10:1.
H2	Team Approach	1 – 5 4	Per interview, staff estimated that 75% - 80% of members saw more than one staff member in a two week period. Most staff interviewed said they see between 50 – 60 members in a typical week. Staff said that they are working on employing a zone coverage strategy, but currently have set days to see people. Staff said that they see all members, and that visits are tracked by the CC, and through communication between specialists. A review of ten randomly selected member records showed that 70% of members saw more than one staff in a two week period. One record showed that for the 30 days examined, the member was only seen by one staff person. Another record showed that the member was out of reach for the last 17 days of the review period following a reported eviction.	• Increase the percentage of members seen by more than one staff member in a two week period, with a goal of 90% or more. Consider if a zone coverage system will increase diversity of member contacts with staff. • The CC and staff should review records to determine if documentation is being consistently entered in the record; if not, identify barriers and possible solutions to accurate record keeping.
H3	Program Meeting	1 – 5 5	The ACT team conducts program meetings Monday through Friday. All members are discussed except during the Wednesday meeting, when specific members are staffed or require clinical consultation from the ACT Counselor (AC). All staff are expected to attend, unless directly supporting member needs such as at court appointments or hospitalization admissions and/or discharges. At the program meeting observed by the reviewers, most staff were present and participated actively. The team Psychiatrist	

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			arrived late and left early due to appointments with members, primarily listening and responding to occasional questions from other staff. Discussion was focused on member status and emerging needs; informal support contacts were also mentioned several times.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated that he spends 30% - 35% of his time providing direct member services, attending staffings, hospital visits, and assisting members with housing issues. Per encounter reports provided to the reviewers, for a 30-day period prior to the review, 9.8% of the CC's time was spent providing face-to-face services to ACT members. Approximately half of contacts occurred in community settings; several contacts were for crisis intervention. Review of member records showed only four progress notes recorded by the CC. The CC said that administrative tasks were the primary barrier to providing 50% direct service to members.	• Increase face-to-face member contacts to 50%, including time spent shadowing and mentoring specialists delivering community-based 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. • Ensure that documentation of direct member services are entered into records in a timely manner. If it is determined that documentation is not being entered, consider available technological solutions to facilitate.
H5	Continuity of Staffing	1 – 5 3	Per data provided by the agency, the ACT team experienced a turnover rate of 54% in the last two years. At the time of the review, seven staff had been with the team for at least one year. Among those positions experiencing the highest rate of turnover were those of Peer Support Specialist (PSS), Nurse, ILS, and SAS.	• Reduce staff turnover rate to no more than 20% in two years to promote 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 survey and exit interviews in order to gather and analyze feedback on why staff leave, as well as factors that promote retention.

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H6	Staff Capacity	1 – 5 4	Per data provided the reviewers for the 12 months preceding the review, the ACT team showed a per month sum total of eight vacancies for a capacity rate of 94%. The vacant positions were: Nurse (4 months), PSS (2 months), SAS (1 month), and Independent Living Specialist (1 month).	• Continue efforts to maintain staffing; see recommendation for item H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	Per staff interview, the ACT Psychiatrist is fully dedicated to the team for 40 hours a week. He usually attends about three program meetings a week. The Psychiatrist is the Chief Psychiatrist of the clinic, but other than a weekly meeting that renders him absent for two to three hours, staff did not feel his accessibility to the team was compromised. Staff said that when they are in the community, the Psychiatrist can be reached through the ACT Nurses. Staff said that he will do home visits when necessary. Staff reported that the Psychiatrist is not available on the weekends; staff said if they need an emergent amendment on the weekend, they go through Urgent Psychiatric Care (UPC).	• See recommendations in O4, Responsibility for Crisis Services.
H8	Nurse on Team	1 – 5 5	Two Nurses are fully dedicated to the ACT team 40 hours weekly. The Nurses help with medical issues such as medication education, injections, labs, coordination with Primary Care Providers (PCP) and medical specialists, and hospital visits. They may provide additional case management services to members who have acute physical health conditions, and liaise between staff and the ACT Psychiatrist. Both work four, ten-hour days, and there is always a Nurse at the program meetings. Neither have responsibilities outside the ACT team, only occasionally providing coverage to other teams at the clinic when assigned nurses are absent. Staff said that the Nurses provide services in the clinic and in the community, and that they	

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			are accessible by mobile phone. Neither Nurse provides weekend coverage.	
H9	Substance Abuse Specialist on Team	1 – 5 3	Two staff share substance abuse treatment responsibilities on the ACT team, the SAS and the AC. The SAS position was vacant at the time of the review. The AC is a Licensed Master of Social Work (LMSW) who has been with the team for approximately 12 months. Prior to joining the ACT team, the AC provided substance abuse treatment in a therapeutic school for children and adolescents with emotional disabilities. The AC said that his Masters program area of focus was mental health and included coursework on Stages of Change and treatment models such as Integrated Dual Disorders Treatment (IDDT) and Cognitive Behavioral Therapy (CBT). The AC receives clinical supervision from the Clinical Director and received ACT training through the RBHA's e-learning program. The AC is responsible for providing cross-training to the other specialists, as well as weekly case consultation, and his interview supported solid grounding in the co-occurring treatment approach.	• Hire and retain an additional Substance Abuse Specialist with at least one year supervised clinical experience or training in substance abuse treatment; provide any necessary clinical oversight in a co-occurring model/stage-wise approach to substance abuse treatment to ensure ability to cross train other ACT team staff.
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has two vocational staff: an Employment Specialist (ES) and a Rehabilitation Specialist (RS). The ES had been in the positon approximately 13 months at the time of the review, and the RS for about six months. Both have been case managers on supportive teams where they appear to have helped members with resumes and referrals to Vocational Rehabilitation Administration (VR). The reviewers were not provided information regarding training in vocational rehabilitation or supporting SMI diagnosed individuals in finding and sustaining employment in integrated settings. Per interview,	• The agency should ensure that both vocational staff receive the necessary training and the necessary supervision/mentoring to assist members in finding and sustaining employment in integrated settings.

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			the ES and RS complete Vocational Activity Profiles with members, assist them with resumes, and make referrals to VR. Staff said that they have a few members doing unpaid work in the clinic snack shop to see how they do and then coach them through filling out job applications. Staff reported one member working in an integrated setting.	
H11	Program Size	1 – 5 5	The ACT team is of sufficient size to provide necessary staffing and diversity. The current team consists of the CC, the ACT Psychiatrist, two Nurses, an ES, a RS, a Housing Specialist (HS), a Peer Support Specialist (PSS), an ACT Specialist (AS), and an ACT Counselor, who has the knowledge and skill to provide both general psychotherapy and co-occurring treatment.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team uses the *ACT Screening Admission Tool* developed by the RBHA. Staff said the typical ACT member is often dually diagnosed, a high utilizer of emergency rooms and psychiatric hospitals, and needs more support for housing and employment. Referrals come from the RBHA, internally from supportive teams, and from hospitals. Although everyone on the team is trained to do screenings, they are primarily performed by the CC, followed by the HS. Screening begins with an interview with the prospective member, as well as a review of any documentation supporting the referral. The CC explains the nature and expectations associated with ACT membership. The referral is also staffed with the ACT Psychiatrist, and if determined appropriate, the individual is invited to join the team. Staff reported no administrative pressure to accept members who do not fit the criteria; administrative transfer sometimes occurs when it	

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			has been determined the member cannot work with their current ACT team due to the individual making threats to staff. All staff interviewed with familiar with RHBA ACT admissions criteria.	
O2	Intake Rate	1 – 5 5	For the six months prior to the review, the ACT team admitted 16 new members: two in April, one in May, three in June, two in July, six in August, and two in September. Staff said that the team does not accept over six new members per month. At the time of the review, staff said there were two people on the waiting list.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management services, the ACT team is fully responsible for psychiatric services, counseling/psychotherapy, and substance abuse treatment. No members receive psychiatric services outside of the ACT team. The AC is trained and supervised to provide general counseling psychotherapy as well as individual and group co-occurring treatment. The AC sees three members for individual psychotherapy and described using cognitive behavioral interventions with a member diagnosed with agoraphobia. The AC said one or two members are seen for psychotherapy by a Spanish speaking agency clinician. No members were reported receiving either psychotherapy or individual treatment for substance use by outside providers. However, it was mentioned in the program meeting that a member would begin substance use treatment with the agency's Ladders program. The team could not be given credit for full responsibility for housing support or employment/vocational services. Per staff interview, approximately 10% of members live in a staffed or semi-staffed setting where they receive	• 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) as needed to assist with job search resources. • As the designated PSH services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team.

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			some degree of on-site services such as groups or medication observation. Staff interviews also indicated that some members receive employment services from outside providers. Staff reported only one person who was working; it was not clear to the reviewers that the vocational staff embrace evidence-based practice principles of competitive employment for SMI/COD diagnosed individuals. Members interested in work appear to first be steered toward unpaid work in the clinic's snack bar to assess work readiness.	
O4	Responsibility for Crisis Services	1 – 5 5	As described in staff interviews, the ACT team is fully responsible for crisis services. Crisis response is 24 hours, seven days a week. The team has an on-call staff, and the CC is the back up to the on call. The on-call phone rotates weekly among the staff. Members are given flyers and business cards with the on-call number as well as staff numbers. The reviewers were provided a copy of the flyer, and it was noted that some staff names were not up to date. Staff will respond in the community to crisis; the CC's encounter report indicated he responded to a crisis call in the community. Staff said that when members call the crisis line, that service transfers the call to the ACT on-call. Staff said that the team Psychiatrist and the Nurses are not available on the weekends. Staff said that it is rare that members need prescriber intervention on weekends but when this occurs, staff transport them to the Urgent Psychiatric Center (UPC).	• Ensure that the crisis services flyer is updated regularly with a list of current ACT staff and phone numbers. • Consider the ACT team's process for triage psychiatric emergencies on weekends, when neither the Nurse nor the Psychiatrist are available, and how this may affect the rate of inpatient hospitalizations.
O5	Responsibility for Hospital Admissions	1 - 5 3	Per a review of the last ten inpatient psychiatric hospitalizations, as well as a review of member records, it appears that at least 50% occurred without the ACT staff involvement. Staff reported that several members often self-admit; several	• Increase ACT team involvement in hospitalizations to 100%. Provide ongoing education and reminders to members and their informal supports on the importance

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			staff speculated that the comfortable environments in preferred inpatient units may motivate some members to self-admit. In two cases, a member was taken to the emergency room by the Fire Department and then transferred to an inpatient psychiatric facility prior to the ACT team being notified. Staff, though, did report of successfully coordinating a hospitalization with a member's family, who allowed staff to transport the member.	of involving the team in decisions to seek psychiatric hospitalization. • See recommendation for O4, Responsibility for Crisis Services.
O6	Responsibility for Hospital Discharge Planning	1 - 5 5	A review of the last ten psychiatric hospital discharges showed that the ACT team was directly involved in 100%. Staff said that discharge planning begins at the time of admission. After the admission, the team has face-to-face contact with the member every 72 hours. Staff said that they maintain regular contact with hospital Nurses and Social Workers at least every other day by phone or email. Discharge planning includes determining where the person will go upon leaving the hospital and submitting housing or placement applications with the RBHA. The team also coordinates "doc-to-doc" conferences between the ACT and inpatient Psychiatrist. Staff is present at the time of discharge, and unless other arrangements are made, staff transport the member to their residence or desired location. Staff assist members in getting prescriptions filled and obtaining necessary groceries or other necessities. All members are scheduled to see the ACT Psychiatrist within 72 hours of discharge and receive face-to-face contact with staff in the community for five-days following discharge.	
O7	Time-unlimited Services	1 – 5	Per interview and a review of agency provided data, the ACT team graduated seven members	• ACT services are designed to be long-term,

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		4	(7%) in the last 12 months and expect to graduate five specific members in the next year. Members are considered for graduation when they have had no hospitalizations or crises in the last 12 months, have housing, no significant substance use issues, do not need prompts for medication or tasks such as hygiene or cleaning, and have meaningful activities such as employment. Staff said that they prepare members for the lower level of care, and do "soft hand-offs", usually to supportive teams in the same clinic.	time unlimited for those individuals who have been unsuccessful on traditional case management programs that do not provide intensity and frequency of support. A graduation rate of 5% or more may indicate that some members may have been inappropriately referred for and admitted to ACT services. • When considering graduating a member, carefully assess the members ability to maintain the same level of functioning on a supportive or connective team once access to the intensive, individualized and community-based supports are withdrawn.
S1	Community-based Services	1 – 5 2	Staff interviewed reported that they spent 75% - 80% of their time providing direct services in the community; seeing members in their homes, the hospital or accompanying them to places like the Social Security office. A review of ten randomly selected member records showed the actual rate to be considerably lower, at approximately 35%. Most members interviewed reported seeing staff at home and/or the clinics. One member reported not having a home visit in two months, while another reported seeing staff at home regularly for medication observation. The reviewers heard some comments in the program meeting that suggest that staff rely on or encourage members to come to the clinic to make contact with them. One staff mentioned that members were at the clinic all day because they attend groups. Reference was made to several members coming to group, but it was not clear if those were co-occurring groups or of some other nature. Some staff said expectations for both documentation and community-based services can run into	• Rather than encouraging members to come to the clinic, staff should focus on providing community-based services (with a goal of 80%), where staff can more effectively assess, monitor, and assist in problem solving and skill building in natural settings. • Whenever possible deliver groups in the community; groups should be individualized to reflect the member's treatment plan and, if not specific to members identified with a COD, reflect those principles. Small, time-limited groups targeting shared recovery needs, and focused on skill-building that enhances independence and integration, could be scheduled as an alternative to site-based groups. • The CC should regularly review and monitor member records to ensure the appropriate level of community-based contacts. The CC should mentor and coach staff in the

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			conflict due to time, and that current technologies provided are not efficient when working in the field.	community when indicated. • Identify and find solutions to any barriers to timely entry of documentation into the member record. If not already in place, consider technological solutions (i.e. mobile dictation apps).
S2	No Drop-out Policy	1 – 5 5	Per a review of data provided by the agency, the ACT team lost contact with only one member out of 100 (1%) during the last 12 months. That member was reported to the team to have moved out of state. Two other members moved out of state, but the ACT team was able to help coordinate care after locating them with family assistance. Evidence was found in the record review and the program meeting observation that ACT staff make efforts to maintain contact with members and provide support when they travel out of town for extended periods. Four members were identified in custody of the Department of Corrections (DOC) for sentences of six months or longer. One of those members in DOC custody is on Navigator status until release.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team uses an eight-week outreach engagement strategy developed by the agency. The outreach strategy begins after two weeks to one month without contact. Outreach begins with phone calls and home visits to the member's last known address/preferred location. It progresses to include outreach to informal supports, guardians, PCPs, probation officers, payees and advocates, and contacting such entities as hospitals, emergency rooms, shelters, and the morgue. Certified letters are sent out at weeks three and four. By weeks six and seven, cases are staffed to address need for evaluation of the	

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			member for behaviors requiring court-ordered treatment (i.e., Danger to Self or Other) by the mobile crisis team. Staff said that if they are not able to locate the member at eight weeks they are stepped down to Navigator status, and those staff continue outreach.	
S4	Intensity of Services	1 – 5 3	A review of ten randomly selected member records found that members received an average of 53.25 minutes of face-to-face service each week from ACT staff. Individual averages across the ten records ranged from 25.50 minutes on the low end to 189.75 on the high. The member receiving the lowest amount of service time was out of contact with the team for the majority of the period examined by the reviewers. The member with the next lowest amount of service time received several services documented by clinical staff not assigned to the ACT team; time spent by non-ACT staff was not calculated into the scoring for this item. Some records reflected primarily clinic-based contact with the Nurse to receive bubble packs or injections, and brief check-ins with other ACT staff, while other records showed home visits for medication observation and environmental assessment only.	• ACT teams should provide an *average* of two hours or more of face-to-face services per week. This is based on all members across the team; some may need more and some less week to week based on their individual needs. • Focus on delivering community-based contacts that are individualized and geared toward building skills that help the member achieve goals toward his or her unique recovery vision. • Ensure that services are delivered by staff assigned to the ACT team.
S5	Frequency of Contact	1 – 5 3	Per the record review, members of the ACT team receive an average of 2.75 contacts with ACT staff per week. Individual averages showed 1.25 contacts on the low end to 15.75 on the high end.	• The ACT team should strive to provide members with an average of four or more contacts per week. Contacts should occur in community settings whenever possible and should be purposeful, person-centered, recovery oriented. • See recommendations for S1, Community-Based Services.
S6	Work with Support	1 – 5	Estimates of how many members have an informal	• Continue efforts to achieve four or more

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	System	3	support system varied considerable between staff, from 45% - 87%. Staff reported to have at least one contact with an informal support monthly for all or most of those members with an informal support system. The reviewers heard several mentions of contacts with family members during the program meeting they observed. Some members interviewed said that their adult children communicate with the ACT team. The record review showed the Act team has 1.70 contacts per month for each member with an informal support system. One record showed ten contacts with a sibling to collaborate on crisis intervention and hospital admission and discharge.	contacts per month with informal supports; regularly revisit with members the benefits of allowing communication between ACT staff and informal supports. • Consider helping members expand their definition of informal supports to consider unpaid helpers other than family such as clergy, neighbors, and member of the peer community, such as relationships at peer-run organizations. • Maintain current Release of Information forms (ROI) to include informal supports. • Consider informal supports as adjunct members or allies of the treatment team, and check in with them where appropriate to obtain their feedback about member needs, functioning, and progress, as well as provide psychoeducation supporting the relationship.
S7	Individualized Substance Abuse Treatment	1 – 5 3	While it was noted in staff interviews and the program meeting that the AC works with ACT members on substance abuse issues, it was unclear to the reviewers how formalized and structured those individual sessions are. The AC reported seeing about half of the 38 members identified with a COD in individual psychotherapy focused on substance use, scheduling about five appointments daily both in the home and at the clinic for either 15 minutes (twice weekly) or 30 minutes. The agency provided the reviewers with dates of substance abuse counseling between September 5 and October 6, 2017, which indicated seven members were provided 11 sessions; also shown were ten attempted or declined services. The data also showed 20 contacts that were	• The ACT team should provide at least 24 minutes per week of formally structured individual substance abuse treatment across all members diagnosed with a COD. • Consider organizing the AC and SAS caseloads and schedules around the needs of members diagnosed with a COD and their stage of treatment. • Ensure the AC is documenting services provided to reflect individualized substance abuse treatment in a timely manner.

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			identified as case management services. No information was provided as to how long each completed session was held. Although the AC was able to describe how he aligns members' change stages with interventions appropriate to their readiness for change, no clear documentation of individual substance abuse treatment was found in the record review.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 4	Per interview, the AC conducts two co-occurring groups weekly, on Tuesday and Friday. The Tuesday group is geared toward the needs of members in the latter stages of change (Action and Maintenance), while the Friday group targets those in earlier stages. The groups, however, are open to any ACT members. The AC tries to engage each individual on their own stage of readiness. Groups follow a supervisor and agency approved curriculum, *Curriculum-Based Motivation Group: A Five Session Motivational Interviewing Group Intervention*. Each group averages about eight members, or 15 - 18 total weekly attendance; some members attend both groups. Calculated for an average weekly attendance of 17, it is estimated that 45% of members diagnosed with a COD attend at least one substance abuse treatment group per month.	• Continue outreach and engagement efforts to increase substance abuse group participation to 50% of all members diagnosed with a COD.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The AC articulated a solid grounding in dual disorders principles in both interview and during the observed program meeting. However, one group co-occurring progress note identified the topic as "coping skills for AA and NA", indicating some reliance of more traditional approaches. Knowledge of the COD model varied greatly across the team. Some staff demonstrated learning and growing in their knowledge while others occasionally lapsed into language suggesting	• The agency should prioritize on-going training and education for all staff in the dual disorders principles, including continued cross-training clinical consultation by the ACT Counselor. As staff transition on and off the team, training should accommodate for new and less experienced staff, or those whose previous training does not align with evidence-based

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			moral judgment respecting substance use (i.e., use of the word "clean" when referring to a member who had not used substances in a month). Others demonstrated no awareness of the model at all.	approaches. • Continue clinical over-sight in the COD model for the AC, and ensure that the incoming SAS has the same, so that he or she can also provide cross-training and mentoring in this area to the other team specialists.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has a full-time Peer Support Specialist (PSS) who is valued as an equal member of the team. The PSS shares her lived experience, as clinically appropriate, with members and uses her experience to heighten the insight of other specialists. In the program meeting observed by the team, the PSS participated actively and at her own initiative. The PSS described spending more of her time in the community providing peer support and those encounters were fewer but of greater duration.	
Total Score:		**3.93**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	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	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	5
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	4
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**110/28 = 3.93**	
Highest Possible Score	**5**	