ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 11, 2020

To: Dan Ranieri, CEO

From: Karen Voyer-Caravona, MA, LMSW
Thomas Eggsware, BSW, MA, LAC
AHCCCS Fidelity Reviewers

Method

On October 13 – 14, 2020, Karen Voyer-Caravona and Thomas Eggsware completed a review of the LaFrontera-EMPACT Capitol 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 the Central Region of Arizona.

LaFrontera-EMPACT offers behavioral health services to children, adults, and families. LaFrontera-EMPACT operates three ACT teams: two in Phoenix, Comunidad and Capitol (located in the same clinic), and the Tempe team. The fidelity review was originally scheduled with LaFrontera-EMPACT Capitol in April 2020 but postponed due to the COVID-19 public health emergency. Following public health guidance, the review was conducted remotely, using video or phone contact to interview staff and members. It was determined that the record portion of the records reviewed should reference documentation for the period prior to the public health emergency.

The individuals served through the agency are referred to as *members* or *clients*, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

The reviewers participated in the following:

- Observation of a daily ACT team meeting on Tuesday, October 13, 2020 via teleconference.
- Individual interview with team leader/Clinical Coordinator (CC), a Substance Abuse Specialist (SAS), the Employment Specialist (ES), and Independent Living Specialist (ILS).
- Individual phone interviews with three members receiving ACT services.
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Review of agency provided material: the Capitol ACT Brochure; Capitol ACT Weekly Groups calendar; the team *8 Week Outreach* tracking sheet; resumes and training records for the two Substance Abuse Specialists (SASs), the ES, and the Rehabilitation Specialist (RS); substance use treatment resources; and, the Regional Behavioral Health Authority's (RBHA) ACT Admission Criteria tool.

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 5point 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:

- Full-time psychiatric services: Full-time, 100% dedicated psychiatric services to ACT members by a tenured Psychiatrist and two Nurses.
- Program size: With all 12 ACT positions filled, the ACT team is of sufficient size to meet the needs of up to 100 members. In addition, the members can receive primary care from the Nurse Practitioner located at the clinic.
- Responsibility for crisis services: The ACT team provides 24-hour crisis services, seven days a week, and will respond on site when necessary. Members are provided business cards with numbers for all ACT staff and the on-call staff, whose duties rotate daily among the specialists. Evidence of crisis response was noted in the record review.
- No-drop out policy: The ACT team retained 95% or more of the caseload over a 12-month period.
- Assertive engagement mechanisms: The ACT team uses assertive engagement techniques, including street outreach, which was evidenced in member electronic records.

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

- Practicing ACT leader: The CC should deliver face-to-face services to members 50% of the time. Service time can include hospital visits, meeting with members and their natural supports, crisis response, and mentoring specialists during visits to members' homes.
- Continuity of staffing: The agency should investigate solutions to reduce staffing turnover to less than 20% in a two-year period. If not in place, consider staff surveys and exit interviews to identify factors contributing to staff attrition as well as those that support retention within the team.
- Vocational Specialists on the team: Provide necessary training and oversight to both vocational staff to ensure they are equipped to help ACT members find and retain competitive employment. Training and oversight build skills in individualized job development, job coaching, and employer engagement.
- Intensity and frequency of services/community-based service delivery: Increase the intensity of services and frequency of contact with members. Optimally, the majority of services are delivered to members in their communities. Work with staff to identify and resolve barriers, to increase the frequency of contact and intensity of services to members, especially for those members frequently out of contact with the team.
- Work with support systems: Increase engagement with natural supports to an average of four times monthly and ensure timely documentation. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports as partners in member's recovery.
- Co-occurring treatment groups: Ideally, 50% or more of members with the co-occurring disorders diagnosis should participate in a co-occurring group. Staff may benefit from training on strategies to engage members in group substance use treatment. When groups can

safely resume, evaluate the substance use treatment groups to ensure the focus on members with co-occurring diagnoses. Consider developing substance use groups that are specific to member's readiness or stage of change and make referrals accordingly.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team has 90 members who are served by 12 staff. Excluding the Psychiatrist, the member to staff ratio is <8:1.	
H2	Team Approach	1 – 5 4	A review of ten randomly selected member records showed that 80% of members had face-to-face contact with more than one staff in a two - week period. Staff reported that the service community is divided into two regions, both of which are further subdivided into smaller contact areas based on zip codes. Each specialist is assigned an area and contacts for each day are in close proximity to each other. Contact areas rotate daily so that every staff has contact with every member each week. Staff believe the rotating system is effective. Staff interviewed do not think that public health guidance has affected their contact strategy; staff said that they prioritize seeing members to ensure they feel safe and supported. Staff said they have maintained face-to-face contacts throughout the public health emergency by practicing social distancing and use of personal protective equipment (PPE).	• Increase face-to-face contacts members have with more than one staff in a two-week period from 80% to 90%.
H3	Program Meeting	1 – 5 5	The ACT team meets Monday through Thursday for a treatment planning meeting at which the entire membership is discussed. The meeting lasts between one hour to 1.5 hours. All staff, including the Psychiatrist and Nurses attend the meeting on the days they are scheduled to work, unless engaged with a member. On Friday, the Clinical Coordinator meets with specialists to discuss members who need to be seen or require follow up. At the meeting that the reviewers observed	

			via videoconference, staff shared their latest contacts with each member or effort to outreach those who have been difficult to locate and provided feedback and reminders on behavioral and physical health needs. Member response to engagement in services was discussed, with an assessment of change stage.	
H4	Practicing ACT Leader	1 – 5 3	It was reported to the reviewers that the CC does provide a considerable amount of direct member services, both in the clinic and in community settings. Records showed the CC have numerous brief contacts with members when they are in the clinic, inquiring as to their needs or recent concerns. Some records showed the CC attending staffings or Adult Recovery Team meetings with members and specialists present. The CC also facilitates a weekly mindfulness group, and supporting evidence was found in member records. It was also reported that the CC shares admission screening duties with team specialists and responds on-site to crisis calls with the on-call when a safety need has been assessed. Encounter data provided to the reviewers for the month preceding the review showed that 18.5% of the CC's time was spent providing face-to-face member care.	● The CC's delivery of direct services to members should account for at least 50% of the time. Live supervision and mentoring specialist during community visits with members counts toward direct service delivery to members. ● Identify administrative tasks currently performed by the CC that can be transitioned to other administrative or support staff, if applicable.
H5	Continuity of Staffing	1 – 5 3	Based on data provided to the reviewers, ten staff left the team in the 24 months previous to the review, for a continuity rate of 42%. This included one staff who has been on extended medical leave from the team. The SAS, Nurse, and PSS position all turned over twice during that period.	● Identify factors that contribute to staff turnover or support retention. Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their supports and helps prevent staff burden.
H6	Staff Capacity	1 – 5 5	Data provided showed a total of seven vacancies for the 12 months preceding the review for a staffing capacity rate of 95%. The Rehabilitation Specialist position was vacant for two months, a	

			Nurse position was unfilled for three months, and an SAS position and the Peer Support position were both vacant for one month each.	
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a full-time psychiatrist who has been with the team for many years. The Psychiatrist is well regarded by staff and members as a good listener, educator, and leader. The Psychiatrist works four, ten-hour days, Monday through Thursday. Staff said that the Psychiatrist only sees members of the Capitol ACT team and does not have outside responsibilities. The Psychiatrist attends most treatment team meetings during the days he is scheduled to work. Staff said that the Psychiatrist is accessible to them in person and over the phone, and that he usually schedules visits in the community on Thursday, in the company of a specialist. Staff said that since the public health emergency, the Psychiatrist will use videoconference in lieu of community visits.	
H8	Nurse on Team	1 – 5 5	It was reported to the reviewers that the ACT team's two full-time Nurses, exclusively serve Capitol Act members. Staff said that the Nurses provide both clinic and community-based services, including through the public health emergency. The Nurses provide the full range of ACT nursing duties, from supporting the Psychiatrist, medication management and administration, including completing labs, coordinating with the pharmacy, and administering injections. The Nurses also coordinate care with outside physical health providers but also with the agency's on-site Nurse Practitioner who serves as the clinic primary care provider (PCP).	
H9	Substance Abuse Specialist on Team	1 – 5	The ACT team has two full-time Substance Abuse Specialists to service the 67 members identified	● Ensure that the new SAS receives the necessary training and qualified clinical

		4	with a co-occurring disorder. One SAS is licensed both as an independent substance abuse counselor (LISAC) and professional counselor (LPC). This SAS has been with the team for slightly over four years. The other SAS joined the team in June 2020 and has over ten years of experience in behavioral health in both inpatient and outpatient care. No relevant experience specific to the co-occurring population was reported. The reviewers were told that the LISAC SAS provides clinical oversight to that SAS.	oversight to provide substance use treatment to the co-occurring population on the team.
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has two full-time vocational staff, an Employment Specialist and a Rehabilitation Specialist. The ES has been in the position since 2019. Although the ES has worked on ACT teams since 2015, no evidence of past experience in helping people serious mental illness find and competitive work was presented. The RS has been in the position for six months and has no recent experience assisting people with an SMI find and retain employment. The agency generated a transcript showed brief online trainings taken by the ES and Rs in employment rehabilitation, supported employment, and motivational interviewing. Resumes provided to the reviewers listed duties in their current roles as those of generalists rather than pertinent to the specialist roles.	● Ensure that vocational staff receive necessary supervision to perform functions related to helping individuals identified with an SMI to find and retain competitive employment. Specific training in job development and job coaching is recommended.
H11	Program Size	1 – 5 5	At the time of the review, the ACT team's 12 positions covered all specialties and services for a team at full capacity. In addition, the agency has a full-time Nurse Practitioner at the clinic providing primary care for optional integration of physical and behavioral health care. With the team fully staffed in all specialty areas, the ACT team is well positioned to meet nearly all member service needs.	

O1	Explicit Admission Criteria	1 – 5 5	The ACT team uses the explicit written admission criteria developed by the Regional Behavioral Health Authority (RBHA). All staff interviewed could describe the admission criteria. It was reported that screenings are conducted by specialists and the CC and then staffed with the Psychiatrist and team. The Psychiatrist makes the final decision regarding admissions. Staff reported no external pressure to accept individuals who do not meet criteria and that when staff question the appropriateness of a potential admission, a complex case review is conducted with the RHBA.	
O2	Intake Rate	1 – 5 5	The ACT team reported ten admissions in the last six months: four in August; two in September; and one each in July, June, May, and April	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team has primary responsibility for psychiatric services, counseling/psychotherapy, substance use treatment, and mix of employment support and some referrals to vocational service providers, including for paid work and work adjustment training. Slightly over 10% of members, however, reside in staffed settings. The records reviewed showed two members living in housing which have staff located on site.	● As the designated Permanent Supportive Housing 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. ● The ACT model encourages employment in competitive work settings. Use caution in referring to work adjustment and shelters work programs, which do not promote community integration and can be experienced as stigmatizing.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides crisis response to members 24 hours a day, seven days a week. Specialists rotate the on-call phone daily; the CC is the back up. The on-call staff can respond in the	

			community if the crisis cannot be deescalated over the phone; the on-call will staff first with the CC, who will accompany the on-call to the location if it is deemed necessary to ensure safety. The team provides members with information about ACT crisis services at intake, including a business card with the on-call number and the names and phone numbers of all specialists. Staff will help members program the on-call number in their mobile phones as well. Staff reported that members rarely use the community crisis line but when they do, crisis line staff will contact the on-call for team response. Evidence of this was located in the record review.	
O5	Responsibility for Hospital Admissions	1 – 5 4	A review of the last ten psychiatric hospital admissions showed that the ACT team was directly involved with 90%. The team filed amendments on five members on court ordered treatment and petitioned four members as persistently and acutely disabled. One member admitted himself to be inpatient after relapsing with substances. Staff said this member was new to the team and did not reach out, despite having contact numbers. Staff said before seeking an inpatient psychiatric admission, the team will first attempt to bring the member to the clinic to be evaluated by the Psychiatrist in order to look for community-based solutions. If the psychiatrist or triaging Nurse assesses that the member cannot be safe in the community inpatient admissions is recommended to the member. If the member agrees to inpatient care and it is medically safe to do so, staff will transport the member. Amendments and petitions are filed when members refuse inpatient care, and it is assessed the member is a danger to self and/or others or at medical risk. In that case,	• Evaluate contributing factors when members do not seek team support prior to admissions. Ensure members are aware of team availability to assist when members plan to go inpatient. • Maintain regular contact with all members and their support networks (both informal/natural and formal). This may result in earlier identification of issues or concerns relating to members, allowing the team to offer additional supports, which may reduce the need for hospitalization.

			public safety officials will pick up and transport the member to the hospital. Before the emergence of the public health declaration, staff would remain with members until they were admitted and then see them every 72 hours. The Psychiatrist would begin communicating with the inpatient psychiatrist within 24 hours, and the rest of the ACT team would be regularly coordinating care in inpatient social workers and nursing staff by phone, email, and in person staffings. Since the emergence of the public health declaration, inpatient facilities have instituted screenings such as temperature checks at the ER or inpatient units; some hospitals have more restrictions than others. One facility allows staff to be present only at admission and discharge. Other hospitals allow contact with members at Nursing stations, or by phone or video conference. Coordination of care continues as usual but staffings are now conducted over phone and videoconference.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per a review with staff, the ACT team was directly involved in 100% of the last ten inpatient psychiatric discharges. Evidence of coordination of care with inpatient social workers and nurses, including staffings with and without the member present, doctor to doctor phone calls, and visits to the hospital to meet with the member were located in member records. Staff interviewed reported that discharge planning begins upon admission, when staff make contact with inpatient social workers, nurses and other staff. Contacts with inpatient staff may occur three to five times a week. Living arrangements post discharge are of particular concern during this	• Ensure the team follows the five-day post discharge follow up protocol and document contacts. Some teams review staff assignments in the program meeting to be clear on the plan to support the member.

			planning period. Staff attempt to see members every 72 hours while they are inpatient to involve them in decision making. One record showed lapses in documented contact with a member who was inpatient prior to the public health emergency. When members are discharged, staff transport them to wherever they will be living. If family or other arrangements are made for transport, staff said that they follow and ensure the member is settled where they will be living. Staff said that they schedule the member to meet with the Psychiatrist within 72 hours of discharge, although usually within the first 48 hours. Staff said they follow a five-day face-to-face contact protocol after discharge to monitor for needs and to avoid unnecessary readmission. One record, however, showed a gap in the five-day follow up.	
O7	Time-unlimited Services	1 – 5 5	During the 12 months before the review, five members transitioned off the team. Two members graduated with significant improvement. Per staff interview, members may be considered ready for graduation when they have been without inpatient psychiatric hospitalization for a year or more, have demonstrated stability in housing, work or other meaningful activities, and have a support system. Graduation is voluntary and members and staff create an updated treatment plan reflecting a gradual reduction in services and a warm hand-off to a supportive team. Staff reported that two members left the team after entering 24-hour residential care. Staff said that when members move to 24-hour residential care the transition off the team lasts 30 – 60 days.	

			A fifth member asked to leave the team, and, although the team preferred to continue working with him, accommodated his request, reducing services and transferring him to supportive care. The team anticipates a graduation rate of slightly over 4% in the next 12 months.	
S1	Community-based Services	1 – 5 3	Staff interviewed reported that around 80% of contacts with members occur in the community, and that this rate was unchanged with the public health declaration. The record review (from before the public health crisis), however, showed that 49% of face-to-face contact took place in community. Those contacts occurred at member's residences, at inpatient facilities, at benefits offices, and at peer run agencies. Records showed several members engaged in clinic-based groups that ran for 60 – 195 minutes at a time. Some groups were scheduled, and attended by members, back to back.	● Increase community-based contacts to 80%. ● Avoid reliance on clinic-based groups other than those designed for members with a co-occurring disorder. Focus on service delivery in the community to address individualized needs and skill building goals.
S2	No Drop-out Policy	1 – 5 5	In the 12 months previous to the review four members left the team because they refused services or entered other systems. One member left the team after moving to the Arizona Long-Term Care System (ALTCS). Two members left the team to enter the Department of Corrections for a period of six months or more; one of those was placed on navigation status and will return to the team upon release. One member could not be located after extensive street and family outreach. The team eventually learned that the member had relocated to another state. The team was then able to coordinate with the member's support system and provided the Social Security Administration with the member's address. However, the team was unable to make contact with the member to establish services with a new	

			provider. Excluding the members who entered corrections and the member who entered ALTCS, the team had a drop-out rate of 1%.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The treatment team meeting observed by the reviewers and records examined, showed that the ACT team uses a well-thought out engagement strategy that includes phone call; home visits; contact with emergency services, hospitals, and the morgue; and street outreach. Staff said that outreach lasts at least eight weeks but often extends longer. Outreach efforts are conducted by assigned staff seven days a week. Staff said that they outreach natural and paid supports (i.e., family, guardians, advocates, and probation officers). Staff reported that about 40 members have representative payees and ten have parole officers. Ten members have guardians or advocates. Eleven are chronically homeless and maybe in periodic contact with Central Arizona Shelter Services. No members are dually engaged with the developmental disabilities system.	
S4	Intensity of Services	1 – 5 3	Per ten member records reviewed, over a month's time before the public health declaration, the median intensity of face-to-face service time per member was 64 minutes weekly. Records showed a range from an average high of slightly over 508 minutes to an average low of 29 minutes weekly. Records showed numerous weekly groups, other than substance use treatment groups, that may last as long as 195 minutes. Most of the groups took place at the clinic. Progress notes showed staff frequently offering groups rather than individualized services targeting needs specific to the member. Groups were and remain temporarily suspended due to the public health declaration.	● The team should continue efforts to provide high intensity services in as safe a manner as possible. When conditions allow, members should receive an average of at least two hours of face-to-face contact with staff weekly. The intensity of services may vary member to member or over time, with some members receiving significantly more and some significantly less depending on immediate and emerging needs. ● Providing individualized services can be difficult to accomplish on a team with a high number of groups. Though mindfulness practice and social skills training are beneficial for many ACT members, fine tuning for unique, real-life

				situations where challenges typically occur may be best achieved when provided on an individual level in the community.
S5	Frequency of Contact	1 – 5 3	Records reviewed showed on average, members had 2.5 visits per week with ACT staff. The range showed an average high of 7.5 contacts per week. Seven records showed an average range of between two and 2.5 contacts per week. Three records showed staff making street outreach efforts for significant periods of time during the month time period. One record reflected a member's service being reduced in preparation for a relocation out of state and transition to a lower level of care. Staff reported limited use of telehealth service due to the public health emergency. One staff said that the SAS provided some telehealth services. One staff said that telehealth offers flexibility as an alternative to arrange for contacts with the Psychiatrist. For example, the team can offer telehealth with the Psychiatrist if staff has contact with a member in the community after a missed appointment.	● When conditions allow, provide members an average of four face-to-face contacts with staff per week. Frequency of contact may vary member to member, week to week, depending on immediate and emerging needs. ● Avoid over-reliance on groups to achieve contacts. See Item S4, Intensity of services.
S6	Work with Support System	1 – 5 1	Staff reported that 73 (81%) members of the ACT team have a natural or unpaid support system, and that the team should have a release of information (ROI) or verbal consent to speak with all of them. Staff said that the team has weekly contact with all of them. Staff said that public health guidance related to pandemic has not had an impact on contact with natural supports, who know they can also reach out to the team. All staff have responsibility for outreaching natural supports as part of their daily caseload rotation. During the team meeting, staff made reference to recent and planned contacts with informal supports for ten members.	● The ACT team should have four or more contacts monthly with a natural community support of every member of the team who has one. Community supports can be friends, family, roommates, clergy, or neighbors. Contact can be via phone, email, text, or in person. Regular communication with natural supports can be useful in averting crisis and intervention by emergency services. ● Regularly review member records to confirm that informal support contacts, including emails and phone calls, are documented. Prompting staff to document

			The ten (.10%) records reviewed showed only one contact with a natural support, which is reflected in the score.	contacts reported on in the program meeting may be beneficial.
S7	Individualized Substance Abuse Treatment	1 – 5 4	At the time of the review, 75% (n=67) of ACT members were identified with a co-occurring disorder. Staff interviewed reported that 75% - 80% of those members receive either weekly or biweekly individual substance use counseling for an average of 30 minutes each. At the time of the review, most sessions occurred face-to-face following public health guidance to reduce the risk of viral spread. Most sessions are held out-of-doors, and rarely in homes unless the member has been medically cleared. Some sessions have been held telephonically due to quarantine. Staff reported using Integrated Dual Disorders Treatment (IDDT) approaches, including cognitive behavioral techniques and Dialectical Behavioral Therapy techniques. Of the ten records reviewed, seven were those of a member identified with the co-occurring diagnosis. A calendar of one SAS that coincided with the record review period showed 43 individual substance use treatment sessions scheduled with members with the co-occurring diagnosis. The number of completed sessions was not indicated, however, a total of four individual substance use counseling sessions were counted in records reviewed, with an average of 13 minutes. It was not clear from records reviewed that all specialists regularly use motivational strategies to move members with the co-occurring diagnosis through change stages related to substance use.	● Provide members identified with a co-occurring disorder an average of at least 24 minutes of formal, individual substance use treatment weekly per month. ● The entire team should be intentionally collaborating to engage members identified with a co-occurring diagnosis in substance use treatment using a stage-wise treatment approach; specific training in motivational interviewing is recommended. Technical assistance in this area may be helpful.

S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff reported to the reviewers that following the declaration of the public health emergency, co-occurring treatment groups were suspended temporarily. Staff said that prior to then, the SAS's offered four substance use treatment groups: Relapse Presentation, Coping Skills, Substance Use Recovery, and Recovery Skills. Staff said that they used curricula from Hazelden and SAMHSA. Staff said that between two and six members attended each group, and that nobody was turned away from the groups regardless of whether or not they carried the COD diagnosis. Staff said the team plans to resume groups soon, following public health guidance.	● Co-occurring groups should be targeted specifically to the ACT team's co-occurring membership. Open groups diminish the individualized focus on how substance use intersects with serious mental illness. ● Market substance use group to members according to their stage of change. For example, members in pre-contemplative and contemplative stages of change may be more motivated to attend groups that focus on increasing intrinsic motivation for change such as general health and wellness, the mind-body connection, and harm reduction strategies that support retaining employment. Preparation and Action stage members may be better suited to groups that increase efficacy and optimism that change is possible through building skills to set limits with self and others, budget time and money for enjoyable activities unrelated to substances, and finding a sober peer group.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Staff interviewed reported that the team embraces harm reduction as more realistic for most members with a co-occurring disorder than abstinence expectations. Staff said that they support abstinence when it is the member's stated goal. Harm reduction was discussed in terms of amount, frequency, and lethality. Staff interviewed said that they use the IDDT treatment model. Relias online courses completed by some staff other than the SASs included Motivational Interviewing in Clinical Practice and Integrated Treatment for Co-Occurring Disorders. The team reported that they do not refer to 12-step programs, nor were they evidenced in the	● Review with staff how IDDT and stages of change are distinguished. There are resources online that can introduce staff to the complementary aspects of the two models: IDDT; and stages of change. ● Ensure that all staff are provided clinical oversight in a stage-wise approach to treatment, including how specific interventions are directed to members depending on their stage of treatment. Training staff in a comprehensive stage-wise treatment model may help the team engage members with the COD diagnosis in substance use treatment and to maintain consistent service if SASs transition off the

			records reviewed. However, information on adjunctive 12-step groups are provided upon request as a community resource. Staff said that they do refer members to detoxification programs when medically indicated due to frequent withdrawal symptoms, especially from alcohol and benzodiazepines. Although the team appears to be primarily based in the co-occurring disorder model, based on the treatment team meeting observed, the record review and interviews, some staff may not clearly differentiate the concepts of stages of change from the stage-wise treatment approach. Stages of change language appears to be used to classify rather than a mechanism by which the team strategizes for the next contact, coordinating interventions designed to move members toward the next change stage. Members with the COD diagnosis do not appear to be guided toward groups that target their change stage, and all substance use treatment groups are open to all ACT members. It was not clear to what extent clinical oversight specific to that framework has been provided the entire team.	team. Optimally, all specialists are supporting consistent evidence-based co-occurring treatment.
S10	Role of Consumers on Treatment Team	1 – 5 5	It was reported that the ACT team has a more than one staff with the lived experience of recovery from serious mental illness. The team has a Peer Support Specialist (PSS). Staff interviewed said that the PSS educates members on the recovery experience and provides the treatment team with the peer perspective. Staff said the PSS carries the same responsibilities as other specialists on the team.	
Total Score:		4.11		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	5
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	4

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
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	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	115/28 = 4.11	
Highest Possible Score	**5**	