**ASSERTIVE COMMUNITY TREATMENT (ACT)**
**FIDELITY REPORT**

Date: January 11, 2022

To: Peggy Chase, President and CEO

From: Annette Robertson, LMSW
Kerry Bastian, RN, BSN
AHCCCS Fidelity Reviewers

**Method**

On November 2 –3, 2021 Annette Robertson and Kerry Bastian completed a review of the Terros Health Priest 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.

Terros Health provides services for persons diagnosed with a serious mental illness (SMI) at several locations in the Central Region of Arizona. There are a total of four ACT teams located among three clinics. This review will focus on the ACT Team located at Priest Health Center.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. Delivery of telehealth services, including phone only, were calculated for this review, however those totals are not included in calculating scores for those items that measure in-person contact between the ACT team and members. This review was conducted remotely, using video or telephone to interview staff and members.

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

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

- Remote observation of an ACT team meeting.
- Individual interview with the ACT Manager who is covering the vacant Team Leader/Clinical Coordinator (CC) position.
- Individual interviews with the Substance Abuse Specialist, Housing Specialist, and Peer Support Specialist.
- Individual phone interviews with three members participating in ACT services with the team.
- Charts were reviewed for 10 members using the agency's electronic medical records system, with assistance from the Team Leader.

- Review of documents: *Mercy Care ACT Admission Criteria*; SAS and Rehabilitation Specialist resumes and *Relias* training transcripts, outreach/engagement documents: *8 Week Engagement Chart*, *8 WEEK OUTREACH*, *Contact and Fidelity Guidelines ACT*, *Meet Your ACT Team*, roster of members with a co-occurring disorder, and substance use treatment group sign in sheets.

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:

- The ACT Psychiatrist sees only members of the ACT team, visits them in the community, is easily accessible to staff, and has longevity.
- A team approach is used when delivering services to members in the community. Members see more than one staff in a two-week period.
- The ACT team meets at least four days a week and reviews all members assigned to the team.
- The intake rate is appropriate for the size of the team.
- The team has more than one staff with lived psychiatric experience. At least one shares their story of recovery with members.

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

- The team is understaffed. Secondary positions for the Nurse, SAS, and Vocational Specialist (Employment Specialist) are vacant, as well as the CC. Fill vacant positions. Leadership should consider soliciting feedback from current and exiting employees relating to job satisfaction, among other strategies, to improve continuity.
- Increase engagement with natural supports. Natural supports should be aware of the services the team offers so they can reach out when members require additional support, such as when 24-hour services may be utilized, or hospitalization may be required.
- ACT services should be responsive to member needs, adjusting in intensity and frequency as it relates to members individual needs. Leadership may want to work with staff to identify and resolve barriers to increasing the frequency of contact with members including use of telehealth technologies widely available and utilized. Higher frequency is corelated to better outcomes for ACT members.
- The team would benefit from an improved understanding of co-occurring treatment services. Provide staff with annual training and ongoing mentoring in a co-occurring disorders model, the principles of a stage-wise approach to interventions, and motivational interviewing.

- Improve involvement in assisting members when seeking psychiatric hospital admission. Increased contact and involving natural supports may provide the team opportunities to provide services and supports that would then prevent a member from seeking inpatient psychiatric care.

**ACT FIDELITY SCALE**

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| H1 | Small Caseload | 1 – 5<br><br>4 | At the time of the review nine staff, excluding the ACT Psychiatrist, provided services to 99 members for a member/staff ratio of 11:1. | • ACT teams should maintain a low member to staff ratio in the range of 10:1 to ensure adequate intensity and individualization of services. Continue efforts to hire and retain experienced staff. |
| H2 | Team Approach | 1 – 5<br><br>5 | All staff interviewed spoke about teamwork and shared responsibility for members' care. Staff reported that they are assigned 10 to 11 members daily, rotating geographical zones weekly. Members interviewed reported seeing at least one to two different staff each week. One member reported seeing the same two staff on a regular basis. Per a review of 10 randomly selected member records, 90% of members saw more than one staff member in a two-week period. | |
| H3 | Program Meeting | 1 – 5<br><br>4 | At the meeting remotely observed, the acting CC lead the meeting, asking for additional details from staff and occasionally delegating tasks. The CC referenced *member calendars* during the meeting. All staff were in attendance at the observed meeting by reviewers and all members assigned to the team were reviewed. On days the CC works from home, the Clinical Director runs the ACT team meeting. The CC reports that the team meets four days a week and another day is used to review more difficult cases. The CC stated that if the entire team is not in attendance, the team will adjust the day to ensure all staff are present to review cases more in depth. | • The acting CC should lead all meetings and when unable to attend in-person, should utilize technology available, i.e., teleconferencing, to support continuity of care for members, rather than rely on clinical staff outside the team.<br>• When planning dates to review cases more in depth, consider staff scheduled workdays and allow participation via teleconference to allow flexibility in meeting member needs. |
| H4 | Practicing ACT Leader | 1 – 5 | The ACT Manager reported seeing members in the office, in the community, and at their homes | • The CC should provide in-person services to members 50% or more of the time. ACT |

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| | | 2 | including assisting with transportation, and delivering medications to their homes. Coordination of care activities include guardians and inpatient psychiatric care teams. The ACT Manager reported delivering about nine hours of in-person and no telehealth activities with members during the month before the review. *The fidelity tool does not accommodate delivery of telehealth services.* | leaders who have direct clinical contact with members are better able to model appropriate clinical interventions and remain in touch with the members and their needs served by the team.<br>• Ensure all services delivered to members of the ACT team are documented in member records. |
| H5 | Continuity of Staffing | 1 – 5<br><br>4 | Based on information provided, the team experienced turnover of 33% during the past two years. At least eight staff left the team during this period. Evidence in records showed occasional coverage from non-ACT staff. Vocational Specialist positions had the highest turnover. One member interviewed expressed concern with staff turnover, especially relating to the recent vacancy of the team lead. | • Ensure specialists are provided training and support in their specialty area. Being supported to provide services to members in the areas of staff's personal interest may bring more value to their work and to the team.<br>• Ensure all services delivered to members are by ACT staff in order to provide continuity of care to members. |
| H6 | Staff Capacity | 1 – 5<br><br>4 | In the past 12 months, the ACT team operated at approximately 89% of full staffing capacity. Records reviewed showed evidence that a non-ACT nurse provided services to ACT members during a month period reviewed. The Employment Specialist and Nurse positions were vacant for multiple months. | • To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions as soon as possible. Timely filling of vacant positions helps to reduce potential burden on staff. |
| H7 | Psychiatrist on Team | 1 – 5<br><br>5 | Staff interviewed reported that the team has a fully dedicated Psychiatrist serving the 99 members of the team. The Psychiatrist is flexible in the delivery of services, meeting members in the community (member homes and residential facilities), at the office, and by telehealth. Few members reportedly have the technology to participate in telehealth so the team supports members apprehensive about meeting in person by providing an office space with a large monitor | |

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| | | | in which they can meet with the psychiatrist via telehealth. Staff said that one day a week, the psychiatrist is in the community and one member record reviewed showed the Psychiatrist meeting with a member at their home. Two members were seen more than once in a 30-day period by the ACT Psychiatrist and all others, but one on outreach, were seen at least once. Staff report that currently, jails and hospitals are not yet allowing ACT team staff to enter to visit with members.<br><br>The Psychiatrist works four 10-hour days per week. Staff report the psychiatrist is very involved in member care and is accessible after hours and weekends by phone, text, or email. Staff cited a recent example when the psychiatrist assisted on a day not scheduled to work. | |
| H8 | Nurse on Team | 1 – 5<br><br>3 | The ACT team has one full time equivalent Nurse assigned to work with members. Working four 10-hour days per week, the Nurse provides psychoeducation, lab draws, injections, and coordination of care with primary care physicians, specialists and inpatient psychiatric hospitals. Staff said the Nurse will deliver medications to members in the community, although only one member record reviewed showed documentation of the Nurse serving members in the community. Records did show member(s) receiving nursing services from staff not assigned to the ACT team. | • Fill the vacant Nurse position. Having at 2 full time nurses is a critical ingredient in a successful ACT program.<br>• Consider taking steps to retain staff already trained and familiar with members by gathering feedback from staff on what measures can be taken to retain them on the team and reduce potential burnout. Provide training and supervision relevant to the work, including the SAMHSA Fidelity Tool, and gain input on how to grow the position beyond how it is already defined. |
| H9 | Substance Abuse Specialist on Team | 1 – 5<br><br>3 | At the time of the fidelity review, the team had one staff, the SAS, providing substance use treatment services to fifty-two members of the team with a co-occurring diagnosis. The SAS has a year experience providing substance use | • Fill the vacant second SAS position. Optimally, ACT teams are staffed with two SASs, each with a year or more of training/experience providing substance use treatment. |

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| | | | treatment services on the team in addition to several years' experience in the private sector. Training records provided showed no evidence of training related to working with persons with a co-occurring disorder, the stage wise approach to treatment interventions, or motivational interviewing. Reviewers were informed that the SAS is provided weekly supervision from a Licensed Associate Counselor. | • Provide all SAS staff with regular supervision from a qualified substance use professional.<br>• Provide annual training to SASs in co-occurring treatment best practices, including appropriate interventions, i.e., *stage wise approach,* based on members' stage of change. |
| H10 | Vocational Specialist on Team | 1 – 5<br><br>3 | The ACT team has one Vocational Specialist (VS) staff assigned to work with members of the team. The Rehabilitation Specialist (RS) has more than two years on the team assisting members to identify needs and connect with resources in their community. The RS was previously in the ES role on the team. Training records provided showed no evidence of recent trainings related to assisting members in finding employment in integrated work settings. | • Seek to fill the Employment Specialist position with someone that has experience assisting members to obtain competitive employment in integrated work settings. Ideally this staff should have experience with job development, supporting individualized job search, and follow along supports.<br>• Provide training and support to the VS staff in helping clients to find and keep jobs in integrated work settings. Optimally, training would include strategies for engaging clients to consider employment, job development, supporting individualized job search, and providing follow-along support. Work in integrated settings is recognized as an essential part of recovery that supports positive outcomes such as higher self-esteem, better control of psychiatric symptoms, and life satisfaction attained through participation in society. |
| H11 | Program Size | 1 – 5<br><br>5 | The ACT team has 10 staff persons. The agency ACT Manager reported acting as the CC, filling that position. The team also has a temporary agency staff assigned to assist the team filling a general role on the team. Three positions were vacant at | • Hire and maintain adequate staffing. A fully staffed team allows the team to consistently provide diverse coverage; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the delivery of |

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| | | | the time of the review, including the CC, the second Nurse and SAS positions. | comprehensive, individualized service to each member. |
| O1 | Explicit Admission Criteria | 1 – 5<br><br>4 | Per the data provided to reviewers and interviews with ACT leadership, the team refers to the RBHA ACT admission criteria. The RS of the ACT team conducts screenings of referrals as well as the ACT Manager. After the member screening, which may include family, legal guardians, and the referring case manager, the ACT team discusses their findings. The Psychiatrist has the final decision on admission. Staff interviewed stated that certain diagnosis are not conducive to the intensity that ACT offers, often exacerbating members symptoms and those referrals are declined. The team denied pressure to accept inappropriate referrals as experience by staff in the processes has strengthened their methods.<br><br>Although not being assigned to the ACT team, the Clinical Director of the clinic where the team is stationed, is screening referrals. | • Admission to the team should be solely determined by the team, not by other agency staff or by administrative decisions. Screening processes for referrals should be done by direct service staff of the ACT team. |
| O2 | Intake Rate | 1 – 5<br><br>5 | During the six months leading up to the review, there were eight new members admitted to the team. The highest rate of intakes was three in the month of September which was an appropriate rate given the size of the team during that month. | |
| O3 | Full Responsibility for Treatment Services | 1 – 5<br><br>4 | The ACT team provides case management, psychiatric and medication management services, substance use treatment services, and housing. Reviewers assessed data provided, information provided through staff interviews, and review of member records.<br><br>Although the Employment Specialist position was recently vacated, the team does provide some | • The team should assume full responsibility for assisting members in the process of finding and maintaining employment in integrated community settings according to the member's preferences. Ideally, ACT teams are advocating for the member's stated readiness as opposed to steering to paid and unpaid work activities, i.e., WAT. Provide ongoing training, guidance, and |

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| | | | employment services. Nearly every note documented by the RS detailed efforts to engage members to explore employment or meaningful activities. However, it was reported and observed in at least one member record, that the use of outside providers is utilized for employment services which includes work adjustment training programs (WAT).<br><br>The team does not provide counseling services to members on the team. Members are referred to agency staff. | supervision to vocational staff related to supports and best practices that aid members to obtain competitive positions. Focus areas should include job development in the community, aligning the job search with member goals, disclosure, and follow-along supports.<br>• Recruit staff that would be able to provide members of the ACT team with counseling/psychotherapy services, rather than rely on providers outside the ACT team. |
| O4 | Responsibility for Crisis Services | 1 – 5<br><br>5 | The team provides 24 hour seven days a week on-call services to members. Staff rotate on-call responsibilities week to week and all staff, except medical, are included in the rotation. There is a back-up staff assigned to the on-call, and the ACT Manager is acting as additional backup. Members interviewed reported being aware of 24-hour services being provided by the team. One member stated having used it in the past and that the services provided by the team helped prevent an inpatient psychiatric hospitalization. Reviewers were provided a copy of the Meet Your ACT Team flier which lists the "ACT Help Line", staff names, roles, and phone numbers.<br><br>Nowhere on the flier does it indicate that the team is available 24 hours to members. The flier had a Nurse listed that left the team in September. | |
| O5 | Responsibility for Hospital Admissions | 1 – 5<br><br>3 | Of the ten most recent psychiatric hospitalizations, the team was directly involved in 40%. Staff reported that most members being admitted to inpatient psychiatric care are court ordered to treatment (COT) and the team is aware when they | • Work with each member and their support network to discuss the team's availability to play a role in crisis and/or hospital admission. Proactively develop plans with members how the team can aid them |

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| | | | are decompensating. For those members the team did not assist, several went on their own without informing the team, and another was picked up by police after a neighbor called out of concern. Staff said it is important for the team to coordinate care with the inpatient team otherwise the inpatient team will take over the member care. Staff interviewed reported difficulty in coordinating care with inpatient teams due to lack of access codes necessary to receive information relating to a member's care. | during the admission, especially when members have a history of seeking hospitalization without team support. As the therapeutic relationship is strengthened, members may increase their communication with the team in times of crisis.<br>• The team should continue to build relationships with the hospitals/inpatient facilities frequented by members, so coordination of care can be fully achieved. |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5<br><br>4 | Staff said the ACT team is usually involved in all psychiatric hospital discharges. Review of data with the Acting CC showed that they were involved in 90% of the ten most recent psychiatric hospital discharges. Staff said even when a member self admits, the inpatient team will inform them so that the team can begin planning for discharge. Although most hospitals are not allowing staff visits, the team does arrange for transport for members upon discharge, ensuring they obtain medications, food, and a safe place to stay as well arrange follow up appointments for the Psychiatrist and Nurse. The team reports following a five day in-person psychiatric hospital protocol. Occasionally, family members may transport members from the hospital, and the ACT team coordinates as best possible in those circumstances. | • Continue efforts to educate and inform inpatient psychiatric hospital staff and member's natural supports of the availability of the ACT team to assist in the discharge process for members. |
| O7 | Time-unlimited Services | 1 – 5<br><br>5 | Staff reported that members that graduate from the ACT team have shown long periods of stability which may include, taking medications regularly, no hospitalizations, participating in meaningful activities, living independently, and requiring fewer services from the ACT team. | |

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| | | | Although, the team graduated eight members in the twelve months leading up to the review, it was reported that the team only expects to graduate two – three members in the next twelve months which is an appropriate predicted rate. | |
| S1 | Community-based Services | 1 – 5<br><br>4 | Per review of ten randomly selected member records the ACT team provides community-based services 68% of the time. One record reviewed had no community contacts by the team. Members interviewed by staff stated they see staff every week or every two weeks at their homes. Staff interviewed reported continuing to see members in the community during the public health emergency, seeing members outside their homes, taking walks with members, while using precautions such as wearing masks and distancing. | • Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in member's communities. |
| S2 | No Drop-out Policy | 1 – 5<br><br>5 | Staff reported closing four cases during the last 12 months. Of those, one client refused services, writing a letter to the team requesting to be closed. Two members were moved to navigator status after attempts to locate were unsuccessful, and one member moved to another state without a referral, for a 4% drop out rate from ACT services. | |
| S3 | Assertive Engagement Mechanisms | 1 – 5<br><br>2 | At least four members were discussed during the program meeting observed as being listed for outreach. Staff reported on recent attempts to connect with members, which included the local homeless shelter and bus stops known to be frequented by one member, however, plans to outreach members were not identified, nor were staff assignments for next steps. | • The Team Lead should lead discussion daily during the program meeting to identify next steps, and staff assignment, when members miss appointments or are showing an increase in symptoms, etc. Ensure outreach efforts are documented in member records. Some teams document these efforts during the program meeting.<br>• If members are not seen at the frequency indicative of ACT services, consider starting |

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| | | | Records reviewed showed one member had no contact for 16 days, although staff did eventually attempt to connect in the community, it was not until phone outreach occurred that the team was able to reconnect. This member was only seen two times during a 30-day period reviewed. Another record showed a member missed an injection appointment, yet staff did not follow up until five days later. No outreach to natural supports was documented in the member record. | outreach efforts immediately after an identified lapse in contact. Consider peer review of documentation to ensure efforts are accurately included in member records.<br>• Continue efforts to involve informal supports as team partners in supporting members' recovery goals and as resources to the team when members are not engaged at the intensity indicative of ACT services. |
| S4 | Intensity of Services | 1 – 5<br><br>2 | The ten records randomly sampled showed a median amount of time ACT staff spent in person with members was 39.25 minutes weekly. Reviewers were provided a copy of the protocol *Contact and Fidelity Guidelines ACT,* which outlines expectations for team contact with members. The guidance suggests members should have 120 minutes of direct face to face (in-person) services delivered each week. One member record had no contacts for the month period reviewed. No members received telehealth services in the ten records reviewed for a month period. However, one member did receive nearly as many phone contacts as they did in-person contacts. This member also had the highest average weekly intensity of in-person services at 95.25 minutes. No members were provided telehealth services *The fidelity tool does not accommodate delivery of telehealth services.* | • ACT teams should provide an average of two hours or more of face-to-face 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 their individual needs, recovery goals and symptoms.<br>• Agency leadership should meet with the ACT team to discuss barriers that may prevent them from increasing their service intensity. This may include an assessment of available technology, schedules, and staff workloads.<br>• Continue efforts to increase intensity of services providing an average of two hours or more of face-to-face services per week to help members with serious symptoms and maintain and improve their functioning in the community.<br>• Leadership may want to consider meeting with ACT team to discuss barriers to high service intensity. |

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| S5 | Frequency of Contact | 1 – 5<br><br>2 | Of the ten records randomly sampled, ACT staff showed an average frequency of 1.75 contacts per week. The record reviewed with the highest average was three in-person contacts a week and also had the highest number of phone contacts in a month period reviewed, seven. The record with the lowest contacts had no in-person contacts, notes indicating the member was identified as being on outreach. When the member was located, they were inpatient. The ACT team attempted to meet with the member via videoconference, but there were technical difficulties, so the telehealth visit was not completed.<br>*The fidelity tool does not accommodate delivery of telehealth services.* | • Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to provide ongoing support. Improved outcomes are associated with ACT teams that are highly invested in the members, maintaining frequent contact to provide ongoing, responsive support. ACT staff should provide frequency of service with the goal of averaging four or more contacts per week, per member.<br>• While under the constraints of the public health emergency, leadership may want to work with staff to identify and resolve barriers to increasing the frequency of contact with members. This may include use of telehealth technologies widely utilized and supported through research for members fearful of meeting in-person with ACT staff, Telehealth for Persons with an SMI · Provide training and support to the team and members to improve ease of use and competency.<br>• Continue efforts to increase frequency of contact with members by ACT staff, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support members. Frequency of contact with members may vary member to member, week to week depending on the immediate and emerging needs. |
| S6 | Work with Support System | 1 – 5 | Staff estimated between 20 – 40 members with a natural support. One staff said that contacts are | • Continue efforts to engage members' natural support systems as key contributors |

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| | | 2 | made with those supports weekly. One staff reported tracking those contacts on member calendars, making sure to connect with those supports weekly. At least eleven members natural supports were discussed during the program meeting observed. Of the ten randomly selected member records, staff had contact with members' informal supports on an average of 0.30 times a month. Yet, most member treatment plans referenced family as a support, and a few specifically addressed members wanting to retain those relationships. One member had little contact with the team for the 30-day period reviewed and had simply been staying with elderly parents. Staff infrequently referenced recent contact with natural supports during the morning meeting observed. It is unclear if the team tracks natural support contacts. | to the member's recovery team especially when supports are identified in members' service plans. Staff should model recovery language and act as a resource to family members and other natural supports.<br>• Evaluate methods of tracking or monitoring staff contacts with natural supports and the documentation of those contacts. Consider regularly review member records to confirm that informal support contacts, including emails and phone calls, are documented.<br>• Increase contacts with natural supports to an average of four per month for each member with a support system. As much as possible, contacts with informal supports should occur during the natural course of delivery of services provided to members. |
| S7 | Individualized Substance Abuse Treatment | 1 – 5<br><br>3 | Data was provided, and staff confirmed, 52 members of the ACT team have a substance use diagnosis. Per interviews with staff, seven members of the team are currently participating in structured individualized substance use treatment provided by the SAS. Calendars were not available to view, but staff said that members are seen on the same day of each week, varying the time to their needs, an average of 20 minutes each session.<br><br>Of the records reviewed four members were identified as having a Co-occurring Disorder (COD). Only one of those members had an individual session documented. | • An average of 24 minutes or more of formal structured individual substance use treatment should be provided weekly across all members with a COD. Ensure other specialists on the team are engaging members with a COD to engage in their recovery through participation in individual substance use treatment.<br>• Use a model that is an evidence-based practice (EBP) for members with a COD. Ensure the SAS receives the necessary training in EBPs, mentoring, and ongoing supervision to provide structured, individual substance use counseling to members identified with a COD. Include training on the stage wise approach to substance use treatment. |

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| | | | Staff report supporting harm reduction and were able to site an example. The member expressed recognition that attending groups supported "sobriety" and expressed a desire to attend the next group. No further documentation was seen of the ACT team efforts to support the member in their plan. One staff said that because most members are in the pre-contemplative stage, motivational interviewing is used. The SAS guides treatment from training gained prior to joining the ACT team. A resource used, The Hijacking of the Brain, describes the risk of brain damage by substance use, but is not developed to be used with persons with a COD. | • For members uncomfortable or fearful of meeting in person, consider telehealth to increase substance use services. Members may require technology support initially in order to successfully engage virtually.<br>• Continue efforts to recruit and hire an additional SAS for the ACT program.<br>• Monitor member participation in individualized substance use treatment provided by the team. Interventions should align with a *stage wise* approach. |
| S8 | Co-occurring Disorder Treatment Groups | 1 – 5<br><br>2 | The team is offering one substance use treatment group weekly. One staff reported five of the 52 members with a co-occurring disorder attend consistently, another suggested a range of 5 – 7 members attending. Sign in sheets provided for a month period before the fidelity review showed three members of the team attended a substance use group provided by the ACT SAS. There were other attendees, however they were not listed by the team as having a COD and some were not assigned to the ACT team. Staff reported taking precautions to ensure members were safe by spacing them throughout the meeting room and encouraging masks. For larger groups, a larger room is available.<br><br>Staff reported using SAMHSA created curriculum, however, it is unclear of the exact materials used.<br><br>One record reviewed documented brief attendance of a member with a COD to a group | • Engage members to participate in group substance use treatment, as appropriate, based on their stage of change. Ideally, 50% or more of applicable members participate in a co-occurring group.<br>• Co-occurring treatment groups work best when based in an EBP treatment model that correlates to the stage of change. Ensure treatment groups are structured around proven curriculum for COD so group effectiveness/outcomes can be measured.<br>• Consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage wise approach. |

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| | | | facilitated by the SAS. The member expressed insight on the value of attending group and expressed a desire to attend the next scheduled group. No further documentation was seen of the ACT team efforts to support the member in their plan. The record also documented attendance of a substance use group provided by staff off the ACT team. | |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 - 5<br><br>2 | Staff appear familiar with stages of change and reported the stages for some members during the meeting observed. Staff were not familiar with the stage wise approach to treating substance use disorders. One staff said the goal for each member is abstinence.<br><br>Of the four member records reviewed diagnosed with a COD, no treatment plans identified substance use treatment as an intervention provided by the team. One record used the term "sobriety" when referencing a member's recovery goals. Another record showed a specialist staff supporting a member to explore recovery by using motivational interviewing techniques. Very few records documented staff engagement with members on next steps in their recovery or encouraging participation in substance use treatment available on the team.<br><br>One staff said staff are trained in harm reduction. Training records did not indicate such training, but some staff had recent trainings in Cognitive Behavioral Therapy for substance use and several had training in stages of change. No staff had evidence of training in treating co-occurring | • Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Dual Disorders Treatment, in the principles of a stage-wise approach to interventions, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new or less experienced staff. Identifying a co-occurring disorder model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in their recovery.<br>• Encourage regular discussion at the program meeting regarding members' co-occurring disorder treatment needs, stages of change, and stage-wise interventions to be utilized to support members in moving toward recovery.<br>• Ensure member treatment plans include goals related to recovery, steps they intend to take, and roles the ACT team will take to support the member. Include individual and group substance use treatment, as well as other supports members identify. |

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| | | | disorders, motivational interviewing, or the stage-wise approach to substance use treatment. | |
| S10 | Role of Consumers on Treatment Team | 1 – 5<br><br>5 | From information gathered during staff and member interviews, there are two staff on the team that have lived experience of psychiatric recovery. At least one of those staff share their story of recovery with members. Staff said that staff with lived experience share the same responsibilities as other staff and have equal status on the team.<br><br>During the program meeting observed, no staff expressed relating to members or encouraged the team to consider the member perspective when discussing recovery goals. | |
| **Total Score:** | | 101 | | |

**ACT FIDELITY SCALE SCORE SHEET**

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

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| 5. Responsibility for Hospital Admissions | 1-5 | 3 |
| 6. Responsibility for Hospital Discharge Planning | 1-5 | 4 |
| 7. Time-unlimited Services | 1-5 | 5 |
| Nature of Services | Rating Range | Score (1-5) |
| 1. Community-Based Services | 1-5 | 4 |
| 2. No Drop-out Policy | 1-5 | 5 |
| 3. Assertive Engagement Mechanisms | 1-5 | 2 |
| 4. Intensity of Service | 1-5 | 2 |
| 5. Frequency of Contact | 1-5 | 2 |
| 6. Work with Support System | 1-5 | 2 |
| 7. Individualized Substance Abuse Treatment | 1-5 | 3 |
| 8. Co-occurring Disorders Treatment Groups | 1-5 | 2 |
| 9. Co-occurring Disorders (Dual Disorders) Model | 1-5 | 2 |
| 10. Role of Consumers on Treatment Team | 1-5 | 5 |
| **Total Score** | **3.61** | |
| **Highest Possible Score** | **5** | |