ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: October 30, 2015

To: Lisa Christen, ACT Clinical Coordinator – Varsity

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ADHS Fidelity Reviewers

Method

On October 6-7, 2015 T.J. Eggsware and Jeni Serrano completed a review of the Partners in Recovery (PIR) Metro Center-Varsity 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.

Partners in Recovery staff provide services out of multiple clinic locations, one of which is the Metro Center campus located in Northwest Phoenix, AZ. Clinic services include ACT, family and peer mentoring, as well as other wellness and recovery activities. The PIR Metro clinic has two ACT teams, and this review focuses on the Varsity team, which serves 99 members.

The individuals served through the agency are referred to as "clients," 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 on October 6, 2015
- Individual interview with the Clinical Coordinator (i.e., Team Leader)
- Individual interviews with one of the team Substance Abuse Specialists (SAS), the Independent Living Skills Specialist (ILS), and the Housing Specialist (HS)
- Group interview with seven members who receive ACT services from the team
- Charts were reviewed for ten members who receive ACT services from the team
- Review of the Mercy Maricopa Integrated Care *ACT Eligibility Screening Tool* and *ACT Exit Screening Tool*, the team "Transfers/New Referrals-Questions to be Asked" form, the team "ACT Team Eligibility Criteria" form, the team "Level of Care Service Screening" form, the team "Outreach Weekly Activity" tracking sheet, and the PIR *Waiver Of Services* form

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:

- Staff-to-member ratio and team size is within identified fidelity standards.
- The team intake rate ranged from zero to four members over the past six months; this is within preferred thresholds for new admissions.
- All staff interviewed report the team is involved during every member hospital discharge, maintaining five day face-to-face contact post discharge, and four week process to support members.
- The team reports few drop-outs; they have retained members at a 98% rate.

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

- The ACT team should increase the intensity and frequency of services to members, with services delivered primarily in the community. Some activities, like group SA treatment, should continue to be offered in the clinic, but to the extent possible, other services should occur in the community.
- Ensure services are primarily provided through the ACT team. Prior to referring a member to an external provider, review what the program will offer that the team is not expected to provide.
- The team should implement a recognized stage-wise integrated dual diagnosis treatment model to standardize the team approach when working with members with substance use challenges.
- SAS staff do not provide individual SA counseling; staff report the SAS staff are not professionally licensed. The SAMHSA ACT model does not require licensure or specific certification as a requisite for staff to provide SA treatment; training and experience are the focus. The ACT team, network, Regional Behavioral Health Authority (RBHA), and the Arizona Department of Health Services (ADHS) should collaborate to clarify if ACT staff In Arizona are allowed to provide individual substance abuse treatment directly or under the supervision of qualified staff.
- Continue to engage informal support networks of members; discuss how the team can support them to assist members. It is recommended the team support and encourage members to identify their informal supports (i.e., people not paid to support members, such as family, landlord, neighbor, friend) and then assist them in acquiring the knowledge, resources and skills needed to support members.
- Consider seeking input from members and frontline staff regarding how services can be improved at the team and system level. Consider consulting with other ACT programs regarding strategies to improve services in lower fidelity areas.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team serves 99 members with ten staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of 10:1. A Family Mentor splits her time between this ACT team and another ACT team at the clinic, but it appears her primary function is to engage family and informal supports.	
H2	Team Approach	1 – 5 (3)	Primary staff are assigned to each member, and during the AM meeting, most member updates or recent contacts were provided by the primary staff assigned. Although the program uses the primary assignment, they also have a process in place to rotate coverage areas to increase the variety of staff contacts with members. However, based on ten records reviewed, 50% of members met with more than one staff over a two-week period. This level of contact appeared to be consistent with some members who report most contact occurs with one primary staff, though most members report they are aware there are other specialty staff positions on the team.	• Ensure the majority of members have contact with more than one staff over a two-week period, and that all services are documented. • If primary caseloads are assigned for specific paperwork-related tasks, ensure the roles of specialty staff are fostered, and they provide cross-training to other staff. Consider orienting members to the current staff contacts for certain types of issues or goals based on staff specialty roles.
H3	Program Meeting	1 – 5 (4)	The team meets four times a week. Most staff, including the Psychiatrist, attends AM meetings four days a week, and the nurse attends three days a week. Based on staff report, all members are not discussed at each meeting; all members are discussed one to two times a week. Certain issues such as hospital admissions, discharges, crisis contacts, and immediate issues that require follow up are discussed along with highlights of caseloads during the other team meetings.	• Preferably, all members are discussed at each team morning meeting. The structure and discussion of members during the morning meeting should be closely monitored. If there are barriers to team communication and coordination, the agency should assess whether the scheduled morning meeting time should be extended to allow for discussion of all members at each meeting.

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			The meeting observed lasted for about an hour and forty minutes; all members were discussed in a similar format, noting current status, recent contact, where and with whom members lived. When asked, one staff confirmed the format of the meeting observed was similar to the day of the week when all members are discussed.	
H4	Practicing ACT Leader	1 – 5 (2)	Based on available information, it appears the CC provides direct face-to-face member services on rare occasions as backup. The primary functions of the team leader are coordination and supervision of the staff and their activities with the members. The CC is aware she should be spending 50% of her time providing direct services to members; the agency recently worked on a plan with the CC to increase the direct services she provides. A productivity report was provided for review, but most services listed were not face-to-face contacts with members, but rather coordination of care with other staff (e.g., staffing notes listing the CC and other team members as participants during morning meetings, phone contacts with other providers). Approximately 4% of CC time is spent providing direct member services per the productivity report review, with 27 minutes of direct member services over a month period, as documented in ten records reviewed. These calculations reflect actual minutes versus billed minutes.	• The CC should increase direct services (i.e., face-to-face contact with members) to 50%, so she can maintain direct contact with members and model appropriate clinical interventions. • Review CC administrative activities to determine if all are essential and required by oversight entities. If all leader administrative activities are deemed essential, review if some or all of those tasks can be transitioned to another staff member, which may allow the team leader to provide increased direct service to members. For example, transitioning the clinical supervision of all ACT SASs to one staff member who can provide oversight and guidance for SA treatment through the ACT team. • Consider assigning the CC as primary contact person for some members, or including the CC in the rotation for other shared caseload responsibilities. Carrying a reduced caseload (six to eight members) as the primary staff assigned may help the CC maintain a level of contact with members and share directly in the experiences of other ACT specialists.
H5	Continuity of	1 – 5	Over the two year timeframe 12 staff left the	• If not in place, the agency should consider

Item #	Item	Rating	Rating Rationale	Recommendations
	Staffing	(3)	team, resulting in a 50% turnover rate.	conducting exit interviews/surveys to determine what contributes to staff turnover, whether at the agency or system level. • If not in place, conduct staff satisfaction surveys to determine what is working to retain staff. For example, when asked how the program or services might be improved, staff report that structured training tools, orientation to the ACT model for new staff hires, and focusing on member outcomes rather than staff productivity may contribute to improved services.
H6	Staff Capacity	1 – 5 (4)	The team operated at 94% of staff capacity over the year timeframe, with eight total vacancies over a 12 month period. The Rehabilitation Specialist (RS) position is vacant.	• See recommendations for H5.
H7	Psychiatrist on Team	1 – 5 (5)	There is one full-time Psychiatrist assigned directly to the 99 member program. The Psychiatrist attends team meetings, has no other administrative duties outside of the team, and does not regularly see members of other clinic teams unless there is an emergency or if a member is under a Court Order for Treatment and only Nurse Practitioners are available. Staff estimates 5% or less of the Psychiatrist's time is spent serving members from other teams.	
H8	Nurse on Team	1 – 5 (3)	One Nurse is assigned to the 99 member program. Per report, the Nurse attends team meetings, has no other administrative duties outside of the team, and does not regularly see members of other clinics unless it is covering for emergencies, which accounts for a small amount of the Nurse's schedule. Nursing duties include medication	• A second Nurse should be added to the team. Optimally, two Nurses for a 100 member program should function as full members of the team and serve as educators to both members and staff. Adding a second Nurse allows flexibility to provide services to members. For example,

Item #	Item	Rating	Rating Rationale	Recommendations
			education, providing injections, serving as liaison with medical providers, etc.	the Nurses can rotate coverage with one Nurse remaining in the clinic, and one providing services in the field. • When a second Nurse is added, consider assigning the Nurses as primary contacts for some members. Some teams assign nurses a reduced caseload, six to eight members, as the primary staff contact. In this approach, the Nurses may be more equipped to coordinate services for members with medical challenges.
H9	Substance Abuse Specialist on Team	1 – 5 (4)	The team has two SASs with one or more years of experience working with dually diagnosed members. One SAS, in the position since January, 2015, has experience working in inpatient settings with individuals with dual diagnosis, knowledge of the 12-step model, and she receives annual training on motivational interviewing. The second SAS has been with the team since May, 2012; their level of training specific to substance abuse treatment could not be verified, but the staff has been in the position for more than one year. Neither SAS is licensed per CC report. Although both SAS appear to have experience working with individuals with dual diagnosis, it is not clear if they receive ongoing supervision and training in an integrated model of treatment.	• The agency and RHBA should train SAS staff in integrated dual diagnosis treatment; ensure the SAS staff receive supervision to monitor the treatment of adults with co-occurring challenges. Familiarize ACT staff with a stage-wise approach to treatment.
H10	Vocational Specialist on Team	1 – 5 (3)	The team has one vocational service staff; the Employment Specialist (ES) position is filled but the Rehabilitation Specialist (RS) position is vacant. The ES assists members in exploring employment options and some resume development, but not with all phases of the employment search, relying primarily on referrals to external employment	• Fill the RS position, preferably with someone who has prior experience in vocational services; ensure both the RS and ES receive supervision and training related to vocational services that enable members to find and keep competitive jobs. Fully integrated ACT teams include vocational

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			support service providers. It does not appear the ES staff member received training or has supervised experience in vocational services to support members to find and keep jobs in integrated work settings, but her past work experience in case management positions serves as a foundation of her efforts.	services to assist members to find and keep jobs in integrated work settings. • The agency has multiple ACT teams; review training and supervision options to determine if one supervisor with vocational experience can provide training to staff in vocational roles across all agency ACT teams.
H11	Program Size	1 – 5 (5)	Although the team is not fully staffed due to the RS position remaining vacant, the team is of appropriate size with 11 staff (excluding administrative support staff).	
O1	Explicit Admission Criteria	1 – 5 (5)	Per staff report, members are generally referred from other teams or the RBHA. If the referral is for a member served on another ACT team, the transfer must occur within seven days. If hospitalized members are referred to the team from the RBHA, and the team declines the intake, they must complete a Notice of Action and Notice of Decision, but the CC reports since she joined the team they have not declined any referrals under these circumstances. Members are screened for ACT, either by the CC or other team staff, using the *ACT Eligibility Screening Tool* developed by the RBHA. In addition, the team utilizes a "Transfers/New Referrals-Questions to be Asked" form during the initial member screening. Once the assessment is done the team speaks with the doctor and the doctor has the final say whether a member is admitted to the team. The CC reports the team has not experienced any administrative pressure to accept members the team determined to be inappropriate for ACT services.	• Ensure all ACT staff are empowered to provide input on potential new admissions to the team; the full team should make the final determination. • Determine if each of the screening forms provided for review is required; eliminate redundancies (e.g., Mercy Maricopa Integrated Care *ACT Eligibility Screening Tool* and the "ACT Team Eligibility Criteria" form have similar content). At the team, provider, and system level, consider noting the date of last revision on forms when updates occur.

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O2	Intake Rate	1 – 5 (5)	Per report, the peak intake rate in the six months prior to review was four members in September, 2015, with no admissions for April, 2015, and admissions ranging from one to two per month for May - August, 2015.	
O3	Full Responsibility for Treatment Services	1 – 5 (3)	Although staff are assigned primary caseloads, members are aware of staff specialty positions, and some identify multiple staff and their specialty area on the team. However, it is not clear if the team fully provides all services directly. The ACT team provides two of five services and refers externally for others. In addition to case management, the ACT team directly provides psychiatric services and medication management to all members. Also, the majority of members receive housing support (e.g., assisting with locating community options, in home independent living support monitoring) only through the team; approximately 8% of members are in residences with varied levels of brokered supports. It does not appear the ACT team provides 90% or more of substance abuse treatment and employment/rehabilitative services directly. The ACT team offers SA treatment engagement and groups, but refers out for individual and some group treatment, which staff report is occasionally mandated through the justice system if more intense services are believed to be necessary. The team engages members to develop employment and rehabilitative goals, but refers out to brokered supports for members seeking employment, with 11 of 12 members referred to external providers for support. The team does not provide counseling services.	• The agency and RBHA should solicit input from ACT staff to identify barriers to the ACT team directly providing the full spectrum of services, and the ability of specialists to function within their assigned roles. The agency, RBHA, and ACT staff should collaborate to develop solutions to reduce the reliance on brokered services. Optimally the team should directly provide a spectrum of services, including vocational support and SA treatment, to the majority of members who receive support in those service areas. • Prior to referring a member to an external provider, review what that program will offer that the ACT team is not expected to provide. For example, if a person wants to work, the team vocational staff should assist in the job search. Fully integrated ACT teams include vocational services to assist members to find and keep jobs in integrated work settings. • The agency should continue to review training and supervision options to ensure staff designated with a specialty area receive monitoring, support, and supervision specific to their role. Explore opportunities for professional development for staff in specialty ACT positions.

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O4	Responsibility for Crisis Services	1 – 5 (5)	The ACT team CC reports the team provides crisis services coverage, with staff rotating an on-call phone, a back-up on call, and the CC providing a third level of availability during crisis. The CC reports the list of team contact numbers is provided to members at program intake, and the numbers are updated when there is a new admission to ensure the information is accurate. During regular hours, members are likely to call their primary assigned staff member.	• Ensure all members are provided with the on-call and other staff contact numbers.
O5	Responsibility for Hospital Admissions	1 – 5 (4)	Per report, the ACT team attempts to work with members to assess whether hospitalization is indicated, or if support can be provided to the member in other settings in order to prevent hospitalization. Information was provided for 12 members who experienced hospital admissions from March, 2015 through September, 2015. Three of those were identified as medical admissions, with the team involved in seven of nine psychiatric admissions, and two members self-admitting. Based on data provided, the ACT team is involved in approximately 78% of psychiatric admissions. Per staff report, the team is involved with 80-90% of admissions due to some members electing to not inform the team when they self-admit.	• Ensure consistent contact is maintained with all members served, which may result in the identification of issues or concerns that could lead to hospitalization. See recommendation for S5. Continue to work with each member and their support network to discuss the pros and cons of informing the team of issues that might lead to hospitalization, to potentially divert, or to assist in a hospital admission, if the need should arise. Attempt to address barriers to the team not being involved in all admissions. See also recommendation for S6.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	All staff interviewed report the team is involved in every member hospital discharge. Per report, discharge planning begins at first contact after a member is admitted. The CC reports staff meet with members within 24 hours of admission, then every 72 hours, having the set days of Monday, Wednesday and Friday to visit members who are inpatient. Staff report the ACT team coordinates with inpatient Social Workers, facilitate doctor-to-doctor consultations between the inpatient and	

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			outpatient staff, as well as ACT team Nurse coordination with the inpatient Nurse to discuss medications. After discharge, ACT supports include face-to-face contact for five days and a four-week follow up plan where the team attempts to meet with members three to four times a week.	
O7	Time-unlimited Services	1 – 5 (5)	There were no member graduations reported in the prior 12 months. Per report, all ACT members are served on a time-unlimited basis, with five potential graduations in the next twelve months.	
S1	Community-based Services	1 – 5 (2)	Most member contacts occur in the clinic versus the community. Ten member records were reviewed to determine the ratio of community to office-based services. For those ten records, the median value was determined as 35% of face-to-face contacts in community. This is consistent with member report of most contacts occurring at the clinic; the team focuses on having three staff make contact with members when they go to the clinic, but these interactions are sometimes brief (5-10 minutes) and repetitive in content. Staff estimate they spend between 50-80% of their time in the community. One staff reports they occasionally need to speak with the team Psychiatrist or other staff, which is easier done in the office setting. Though staff confirm they have the resources (including laptops and phones) to work in the community, they report they can't take those items into all settings (e.g., jails).	• The ACT team should increase community-based services to members. The agency should work with program staff to brainstorm ideas to increase community-based services and ensure those are documented accurately. Supportive housing services, assisting with employment goals, peer support services, individual SA treatment, and other skill development activities should occur in the community rather than the clinic whenever possible. • Consider using the on-call phone as the primary contact for staff even during regular business hours rather than relying on a team member "blue-dot" who is office-based. This may aid as the program transitions to provide increased community-based services, allowing staff to be in the field more. • If the team continues to focus on three staff contacts with a member when they are at the clinic, ensure each contact is necessary to support the member. Having multiple contacts in a brief period at the

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				clinic may contribute to a higher frequency of contact (S5), but negatively impacts the ratio of community to clinic-based services, and possibly results in lower intensity of services (S4) due to the brevity of the contacts.
S2	No Drop-out Policy	1 – 5 (5)	ACT staff report they retain members at a 98% rate; during the 12 months reviewed, two members/guardians declined services. This does not include members who are transitioned off the team after 30 days of residential treatment, and members who transfer to different ACT teams.	
S3	Assertive Engagement Mechanisms	1 – 5 (4)	Per report, the team attempts to build rapport with members, and coordinates with legal system representatives, guardians, and payees if involved. The team has a written outreach process outlining the steps the staff should make to engage members who are not in contact with the team. However, it is not clear if this "Outreach Weekly Activity" tracking sheet is always followed. A Notice of Action (NOA) is sent on week five of outreach according to the tracking sheet, but in one record it was noted an NOA was sent within three weeks of last contact due to the member not going to the clinic three times a week for medications, for not completing annual paperwork, and for not signing Releases of Information (ROI), or consent for treatment. There was also an eight day lapse in outreach during that three week timeframe. In another situation, although the team was in contact with a member, the person's guardian, who was a family member, requested closure after taking the member off all medications. The team	• Review the "Outreach Weekly Activity" tracking sheet weekly for disengaged members to ensure each listed activity occurs. Revise the document if necessary to align with the minimum expected steps to occur prior to closure. • Consider sending the NOA later in the outreach process, after other options are exhausted, rather than prompting for the step at week five. Retention of members is a high priority for ACT teams, with outreach being a critical feature. Ensure team provides persistent, caring attempts to engage members in an effort to form a trusting relationship between the member and the ACT team. For example, rather than having the primary staff contact perform follow up, attempt to vary which staff attempt to contact disengaged members.

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			learned just prior to closure that the member experienced an increase in symptoms, but the closure proceeded. It is not clear if the team discussed all steps to retain the member in services if they were concerned (e.g., involving the Office of Human Rights or Public Fiduciary office to review steps they could take).	
S4	Intensity of Services	1 – 5 (2)	The median intensity of service per member was 30 minutes a week based on review of ten member records. The average weekly amount of service time per member ranged from ten minutes to about 126 minutes, with six members receiving 30 minutes or less per week.	• Increase the intensity of services to members, optimally averaging two hours a week or more of face-to-face contact for each member. Explore what actions the team can take resulting in higher service intensity per member. For example, offering a spectrum of services directly by the ACT team rather than referring to external providers may result in higher intensity of services per member, maximize the full potential of the ACT team, and minimize the time spent coordinating with other brokered service providers.
S5	Frequency of Contact	1 – 5 (2)	Staff estimate a high frequency of contact with some members, especially those who receive medication observation services, with about 32 members who receive medication observation support, or medication pill cards/blisters (i.e., bubble packs). The median weekly face-to-face contact for ten members was 1.88 for each member based on record review. The average weekly face-to-face contacts with members over a month period ranges from .75 to 5.5., a mode of 1.25, and six members receiving less than two face-to-face contacts per week.	• Increase the frequency of face-to-face contact with members, not just those who receive medication observations, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services.
S6	Work with Support	1 – 5	During observation of AM meeting, staff	• ACT staff should regularly review with

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	System	(2)	frequently cited who members resided with, including family, significant others, etc. However, it was not clear if the team was in regular contact with these informal supports. There was evidence of team contact with informal supports for about seven members based on morning meeting observation. During interviews, staff had difficulty estimating the average monthly contact with informal supports, noting that informal support involvement varied from member to member. One staff estimated 50-75% of members identified informal supports, and one staff reported 90% of members identified informal supports; the average contact for each member appears to vary by primary staff assigned. Staff report some members decline to sign a ROI to allow staff to communicate with informal supports. The CC estimated about 40% of members had supports, with the team maintaining contact with those supports about every two weeks; a .8 average with informal supports per member per month. There was an average of .6 contacts per member per month documented in the ten member records reviewed. Based on data provided, it is estimated the team averages .5 – 1 contact per month with informal supports for each member.	members the potential benefits of allowing the team to engage their informal supports, and attempt to secure a ROI allowing staff to contact any identified supports. These supports may include family, landlords, employers, or anyone else with whom members have consistent contact. If a member declines to allow staff to make contact with informal supports, this should be documented in the record. Review HIPPA guidelines when developing a team plan to engage informal supports in order to determine to what extent staff can receive and share information with known supports if a member declines to provide a ROI. • If a family member or other support is involved, continue efforts to coordinate with those supports. This includes check-ins with supports when members are doing well and when members experience challenges. Establishing communication may allow the team to provide education regarding serious mental illness, and to enlist informal supports to advocate with members, if needed. • Consider developing a family psychoeducational group where families have the opportunity to expand their social networks, support each other, and learn techniques from each other on how to support members.
S7	Individualized Substance Abuse Treatment	1 – 5 (1)	Based on staff report, morning meeting observation, and record review, staff generally invited members to the SA treatment group as the	• Individual SA treatment should be provided through the team. • The program should ensure staff are

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			primary SA treatment option through the team. The team reports they do not provide individualized substance abuse treatment due to not having a licensed therapist. The team refers members to external providers for individual SA treatment.	trained and receive supervision to provide substance abuse treatment to the population served. • The team, network, RBHA, and ADHS need to confirm whether unlicensed ACT staff in Arizona are allowed to provide individual SA treatment. If unlicensed SASs can directly provide individualized SA treatment ensure staff and programs are oriented to the expectations such as who must provide supervision to staff providing the service. • See recommendations for S9.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	The team offers an SA treatment group once weekly. One SAS staff facilitates the group weekly, and SASs rotate facilitator duties from week-to-week. Staff report of how many members on the team who face co-occurring challenges ranged; one staff reports about 35-36 members and one staff reports 49 members. Staff consensus is that about seven or eight members attend the treatment group through the team at least once monthly. Based on staff report, approximately 14-21% of members with substance abuse challenges attend group treatment through the ACT team at least once monthly. Some members are mandated to specific external programs through the correctional system. The CC also reported the program plans to use a sign in sheet for the SA treatment group in order to track member attendance.	• If members are mandated to attend other SA treatment, educate the legal justice system regarding the spectrum of services that can be provided through a high fidelity ACT team, including co-occurring treatment groups, individual SA treatment, with services based on a co-occurring model. This may help to mitigate the need to refer members to outside providers for services that should be offered through the ACT team. • It is recommended to implement the noted sign in sheet and other possible tracking mechanisms to gain more accurate data on members participating in substance abuse treatment groups. • See recommendations for S9.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	Staff appear to generally focus efforts on harm reduction. The team refers members for inpatient detox & rehab if members are using certain substances such as alcohol, opiates, or	• Implement a consistent, harm-reduction based treatment model; once trained in an integrated dual diagnosis treatment model, empower SAS staff to cross train other ACT

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			benzodiazepines. It is not clear if the team employs a stage-wise treatment approach based on documentation and interview report. During interviews, staff did not identify a specific treatment model. Staff make contact with members to build rapport (i.e., engagement), discuss the potential consequences of use, but appear to primarily offer only SA group using a curriculum developed by the RBHA, and do not directly assist all members to achieve recovery through an integrated treatment approach. The team relies on referrals to outside agencies for individual SA treatment and some group support. The team is aware of a 12-step model of treatment, but the self-help group format is one component of a stage-wise approach to treatment.	staff. Revise program language when describing member substance use (e.g., avoiding the words "clean" or "dirty"). • Ensure staff are familiar with a stage-wise approach to treatment; interventions should be aligned with a member's stage of change. Integrated dual diagnosis treatment training on a recurring basis may empower SAS staff across the system to support members in a consistent manner, based on a proven model. If the clinic does not have the capacity to provide this training or supervision, then the RBHA and agency should work collaboratively to explore alternative training and supervision options.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	Members with lived experience of mental illness are employed on the team full-time, with full professional status; the ACT team has an identified Peer Support Specialist (PSS). However, none of the seven members interviewed were able to identify the PSS on the team; one referred to the PSS who left the team in February, 2015.	• Consider orienting members to all current team specialists, their roles, what members can expect from the staff and the team, as well as contact numbers for the specialists.
Total Score:		**3.57**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	4
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	3
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	3
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	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	1
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	**3.57**	
Highest Possible Score	**5**	