

## ASSERTIVE COMMUNITY TREATMENT (ACT) FIDELITY REPORT

Date: October 24, 2019

To: Rosalie Eddingfield, Metro Omega ACT Team Coordinator  
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AHCCCS Fidelity Reviewers

### **Method**

On October 7-8, 2019, T.J. Eggsware and Karen Voyer-Caravona completed a review of the Partners in Recovery (PIR) Metro Center Campus Integrated Health Home Omega 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.

PIR operates seven outpatient treatment centers serving individuals with Serious Mental Illness (SMI), including the Metro Center Campus Integrated Health Home where two ACT teams are located: Omega and Varsity. This report focuses on the PIR Omega ACT team.

The individuals served through the agency are referred to as *behavioral health recipients (BHR)*, 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:

- Observation of a team meeting on October 7, 2019;
- Individual interview with the ACT Clinical Coordinator (i.e., Team Leader);
- Individual interview with the Rehabilitation Specialist (RS);
- Group interview with the team's two Substance Abuse Specialists (SASs);
- Interviews with five members who receive ACT services from the team;
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of documents, including: *Omega Team Meeting* log; Clinical Coordinator (CC) face-to-face service tracking log, resumes and training records for the SASs and vocational staff, substance use group sign-in sheets, substance use treatment resources, eight week outreach tracking sheet, *Assessing ACT Appropriateness Tool*, and, the Regional Behavioral Health Authority (RBHA) *ACT Eligibility*

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:

- The team is staffed with 11 direct service staff. Staffing is of sufficient size to provide necessary coverage to the 100 members served.
- The team seems to have a collaborative approach to treatment based on interviews and observation. The ACT team meets four days a week to discuss each member of the team. During the team meeting observed, multiple staff contributed to discussions, were involved in planning services, and outlined their efforts to support members.
- The team is staffed with a Psychiatrist and two Nurses. The Psychiatrist, and a Nurse, provide community-based services. One Nurse takes the lead to assist members to address medical health conditions, including coordination and attending appointments. The other Nurse assumes primary responsibility for other aspects of treatment, and to provide services to members at the office.
- The ACT team provides crisis support to members. Members interviewed confirmed that the team is available after business hours by phone and can meet members in the community. The Psychiatrist and Nurses are available for consultation after hours.
- The team maintained consistency and continuity of care for members with a low admission rate, and few members transitioned off the team over the year prior to review.

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

- Work to shift services from the office to the community. ACT teams should perform 80% or more of contacts in the members' communities. Facilitate skills training in more natural settings where challenges are most likely to occur. Documentation showed nearly half of contacts occur in the office. Other than substance use treatment groups, the team should evaluate the benefit of holding clinic-based groups rather than individualized community-based services.
- Increase the intensity of services and frequency of contact with members. Work with staff to identify and resolve barriers to increasing the frequency of contact and intensity of services to members. Consider monitoring the diversity of staff contacts with members.
- Increase engagement with natural supports as partners in supporting members' recovery goals. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or utilize recovery language when they interact with members. Training staff on informal support engagement strategies may be helpful.
- Ensure treatment is offered to members with co-occurring diagnoses. Monitor the provision of individual treatment to ensure it occurs and is documented. Evaluate the substance use treatment groups to ensure the focus on members with co-occurring diagnoses.

**ACT FIDELITY SCALE**

<b>Item #</b>	<b>Item</b>	<b>Rating</b>	<b>Rating Rationale</b>	<b>Recommendations</b>
H1	Small Caseload	1 – 5 5	The team serves 100 members with ten staff that provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of 10:1. A float staff (titled Senior ACT Specialist), provides services to some Omega members and a Licensed Associate Counselor (LAC), provides general counseling to ACT members. The Senior ACT Specialist and counselor were not factored into the member to staff ratio.	
H2	Team Approach	1 – 5 4	One staff estimated that 50% of members receive face-to-face contact with more than one staff over a two-week time frame. Based on sample records, 70% of members received face-to-face contact with more than one staff over a two-week period.	<ul style="list-style-type: none"> <li>Confirm that attempts and successful contacts are documented. Ideally, at least 90% of members have contact with more than one staff over a two-week period.</li> </ul>
H3	Program Meeting	1 – 5 5	Staff said that all members are discussed during the team meeting, held four days a week. The team Psychiatrist attends at least two full meetings weekly and specialists attend on the weekdays they are scheduled to work. Some staff schedules cover weekend hours. During the meeting observed, there was evidence of staff taking the primary role in implementing services related to their specialty positions. Staff highlighted progress made by some members.	
H4	Practicing ACT Leader	1 – 5 2	The CC attends program meetings and provides supervisory coverage to the Varsity and Omega teams due to a CC vacancy on the Varsity team. The CC reported making frequent member contacts when covering only Omega, 40-50 per week. In ten member records there were few examples of services delivered by the CC over a recent month. Based on review of the CC's productivity report over a month time frame, the	<ul style="list-style-type: none"> <li>The CC should provide direct services to members. Covering two teams limits the CC's time to provide direct services.</li> </ul>

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			CC made six Omega member contacts. The report listed service units (17), not actual time.	
H5	Continuity of Staffing	1 – 5 4	Based on data provided by the agency, five staff left the team in the most recent two-year period, resulting in about a 21% turnover rate. The team experienced turnover at the Peer Support Specialist (PSS), Nurse and SAS positions. One temporary staff provided coverage.	<ul style="list-style-type: none"> <li>Continue efforts to retain experienced staff. When necessary, examine employees' motives for resignation, and attempt to identify causes for employee turnover. Optimally, turnover should be no greater than 20% over a two-year period.</li> </ul>
H6	Staff Capacity	1 – 5 4	The team operated at approximately 89% of staff capacity over the past year. There was a total of 16 months with position vacancies. The PSS position was vacant most of the prior year. Staff said that not all certified PSSs hold a license to drive.	<ul style="list-style-type: none"> <li>When applicable, fill vacant positions with qualified staff as soon as possible. In an effort to support retention, ensure staff receives training and supervision for their specialty.</li> </ul>
H7	Psychiatrist on Team	1 – 5 5	The Psychiatrist works four, ten-hour days and attends team meetings at least two days weekly. Staff said that the Psychiatrist provides services to members from other teams and fulfills her duties as Chief Psychiatrist for the clinic on a fifth day of the week, outside of 40 hours with the Omega team. Staff reported the Psychiatrist is available for consultation on evenings and weekends. The team uses a text application for communicating issues relating to members. Staff said that the Psychiatrist monitors and responds to discussion. Staff said that the Psychiatrist routinely provides community-based services to members and examples were found in sample records. Members interviewed reported they feel comfortable sharing with the Psychiatrist.	
H8	Nurse on Team	1 – 5 5	Two full-time Nurses are assigned to the team. Both work four ten-hour days and attend team meetings three days a week. Staff reported that the Nurses are accessible and responsive, including over the weekend and outside of clinic hours. One Nurse is the lead Nurse for the clinic.	<ul style="list-style-type: none"> <li>Monitor and minimize the amount of time the Nurses spend providing coverage to Varsity ACT team members. Due to the Omega team member census, the two Nurses should primarily only serve Omega members.</li> </ul>

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			Staff said that the Nurse performs administrative responsibilities on a fifth day, separate from ACT hours. Examples of the Nurses providing services to members in the community were found in records. One Nurse works mainly in the office. The second Nurse coordinates medical care and typically meets members in the community, at their homes, or to attend medical appointments with them. Staff said that the Nurses may occasionally be called on to provide services to members from the Varsity ACT team.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team has two SASs, including one in the position for more than a year. The second SAS attained a Master of Social Work (MSW) before joining the team in March 2019. In addition to time on the team, the second SAS's resume shows prior substance use treatment experience of more than a year. Staff said that the SASs receive weekly supervision in substance use treatment from a Licensed Clinical Social Worker. Staff training records show staff participated in few substance use treatment topics.	
H10	Vocational Specialist on Team	1 – 5 5	The team employs an ES and an RS. Both have been in their positions for more than a year. Based on staff interviews, the vocational staff assists members to explore competitive employment. Staff said that the vocational specialists participate in quarterly RBHA trainings. A recent topic was resume writing. Staff training records show few recent relevant vocational service topics.	<ul style="list-style-type: none"> <li>Ensure both vocational staff receive ongoing training, guidance, and supervision related to vocational supports and best practices that aid members to obtain competitive positions.</li> </ul>
H11	Program Size	1 – 5 5	At the time of review, with 11 direct service staff, the team is of sufficient size to provide coverage.	
O1	Explicit Admission Criteria	1 – 5	Staff reported most referrals originate from other teams at the clinic. New ACT staff learn the	

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		5	screening questions to ask by using the <i>Assessing ACT Appropriateness Tool</i> . The team uses the <i>ACT Eligibility Screening Tool</i> developed by the RBHA to screen for potential admissions. The screener presents the information to the whole team and the Psychiatrist makes the final decision if members join the team, with no external requirements to accept admissions. Per report, due to the member census, rate of referrals, and a waitlist, there is little need for recruitment.	
O2	Intake Rate	1 – 5 5	Over the prior six months, the peak member admission rate was four during August 2019. There were zero admissions April 2019; one each month during June and September 2019; and, two each month during May and July 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	<p>In addition to case management, the team directly provides psychiatric services, substance use treatment, and most employment and housing support.</p> <p>The RS and ES provide employment related support (e.g., resume writing job searches) to 20-25 members. One staff reported that during the prior month, the vocational staff provided pre-employment services to about 15 members. Staff reported that one member is with a brokered provider for Work Adjustment Training (WAT).</p> <p>The team provides in-home services and assists members to explore housing options. During the team meeting observed, staff discussed ILS services and the Housing Specialist exploring residence options with members. Staffed settings where some ACT members reside range from formal settings to less formal group living</p>	<ul style="list-style-type: none"> <li>• The team should be capable of directly providing individual supportive counseling psychotherapy (with the necessary clinical supervision and oversight) for members.</li> <li>• Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff support. Monitor the number of members in staffed residences so that, optimally, no more than 10% of ACT members reside in settings where other social service staff provides support.</li> <li>• Consider noting on the <i>Omega Team Meeting</i> log if members live in a staffed residence.</li> <li>• Evaluate members' circumstances and housing options before they are referred to brokered vocational serviced providers.</li> </ul>

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			<p>arrangements. Staff accounts on the types of staffed settings varied. It was not clear if there was shared awareness of members' housing statuses. Two staff estimated a low of about 7% of members staying in staffed residences, but another staff estimated about 19%, and one was unsure.</p> <p>Staff said that counseling is available through an LAC at the agency and that no members receive counseling from other providers. One staff reported that, on occasion, members may be referred to a brokered provider if they elect to not work with the agency counselor. Neither the Senior ACT Specialist or counselor who serve the PIR ACT teams were factored into this item. There was limited verifiable evidence of services rendered by the two staff in ten member records, nor were they listed on the staff roster provided.</p>	
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the ACT team is available to provide crisis services 24 hours a day, seven days a week, including responding to members in the community. The CC serves as backup after-hours. Some staff work weekend shifts. Members interviewed confirmed that the team is available after business hours and that staff provides a contact list that includes the on-call and staff phone numbers. The Psychiatrist and Nurses are available for consultation.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Based on information provided, the ACT team was directly involved in eight of the ten most recent hospital admissions. Staff said that Omega members infrequently receive inpatient psychiatric treatment. Based on information provided, the ten most recent psychiatric admissions included members hospitalized during April 2019. One	<ul style="list-style-type: none"> <li>• Maintain regular contact with all members and their support network. This may result in the identification of issues or concerns that could lead to hospitalization. Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist</li> </ul>

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			<p>admission was reported each month during May, June and July 2019. Psychiatric admissions increased during August 2019.</p> <p>During office hours, staff arranges for consultation with the Psychiatrist and/or Nurse before members receive inpatient treatment. Members can contact the team on-call staff after hours. Staff said that if a member requests inpatient services, staff will transport them to the hospital.</p> <p>Staff said that the team follows the <i>Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual</i> to guide their services when members are inpatient. Staff said that they meet with members within 24 hours of admission, and every 72 hours thereafter. Staff reported that doctor-to-doctor contact between the inpatient provider and Psychiatrist occurs.</p> <p>Staff said newer members are more likely to self-admit and that newer members may not be accustomed to the intensity of services and availability of ACT staff. As staff build rapport, newer members are less likely to self-admit.</p>	<p>with hospital admissions. More frequent and intense individualized provision of community-based services may afford ACT staff further opportunities to assess and provide interventions to reduce psychiatric hospitalizations and to build collaborative relationships with members' informal supports.</p> <ul style="list-style-type: none"> <li>The RBHA and PIR should evaluate what factors contributed to the Omega ACT team successfully supporting members in their communities. Low psychiatric admission rates were reported for May, June and July 2019.</li> </ul>
O6	Responsibility for Hospital Discharge Planning	1 – 5  5	<p>Staff said that the ACT team was directly involved in each of the ten most recent hospital discharges. One member left the state without informing the team and was hospitalized in another state. Staff reported that they coordinated with the inpatient provider and the member's family. The member left the hospital before discharge support could be established. Staff from the team typically meets members at discharge to provide transportation to their discharge setting. Staff said that they have face-to-face contact with members for five days</p>	



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			after a hospital discharge.	
O7	Time-unlimited Services	1 – 5 4	Staff reported that over the prior year, two members graduated from the team. In the upcoming year, staff projected four to six graduates. Staff said three members are currently scheduled to graduate. Staff reported that some members are reluctant to transition from ACT due to the level of support provided. Staff said that they follow the RBHA's ACT EXIT Criteria Screening Tool. Staff said that they talk with members about the services they receive from ACT. If the services provided do not justify ACT services, staff discuss graduation with the member. Staff said that graduation timelines can vary by member and is determined by the member and the Psychiatrist.	<ul style="list-style-type: none"> <li>The team should work toward maintaining an annual graduation rate of fewer than five percent of the total caseload.</li> </ul>
S1	Community-based Services	1 – 5 3	<p>One staff reported that they spend about 50% of their time in the community. Another staff reported that 80-85% of their contacts with members occur in the community. In ten member records, a median of 54% of services occurred in the community. Some members interviewed reported they met with staff more often at the office. Two members said staff visits their home about every three months, and one said staff visits weekly.</p> <p>There were examples in member records of staff inviting members to attend clinic-based groups. In one example, members watched and discussed a movie. Based on records, some staff provide mostly office-based contacts.</p>	<ul style="list-style-type: none"> <li>Shift the locus of service from the office to the community. Optimally, ACT services are delivered in the community where challenges are more likely to occur. Delivering services in the community offers opportunities for staff to directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting. For members who prefer groups, determine if the activity can be transitioned to a community setting.</li> </ul>
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the prior year, the team retained more than 95% of members. Three members left the geographic area. Staff assisted one member to engage in services in the new	

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			location. The two other members left the geographic area without notifying the team and were subsequently hospitalized. Staff attempted coordination with the inpatient providers, and transitioned services for one of the members. The second member left the hospital without supports. No members left the team because they refused services or could not be located. A <i>Navigator</i> system is in place, but no members transitioned off the team to that status in the prior 12 months, per staff report. For some planned transitions, when applicable, the team uses the Medical ACT Admission Screening tool to screen current ACT members for the Medical ACT team (M-ACT).	
S3	Assertive Engagement Mechanisms	1 – 5 4	<p>Staff provided a copy of the checklist the team uses to track eight weeks of outreach to members not engaged in treatment, or if their location is unknown. Outreach categories include: phone calls to members and emergency contacts, home visits, contact with pharmacies, hospitals, jails, and the morgue. The checklist prompts for four attempts per week and two must be in the community. A certified letter is sent at week four.</p> <p>During the program meeting, staff discussed outreach to members and their methods to engage some members. However, in records, over a month time frame, there were gaps in documented outreach or contact of a week or more for six of ten members. Sample member calendars were collected for 20 members and some showed comparable lapses in engagement.</p>	<ul style="list-style-type: none"> <li>Monitor contacts with members. Ensure community-based outreach occurs and is documented. It may be useful to assign one staff to review documentation in member records during the team meeting to confirm recent contacts occurred so that the team can proactively assign staff to outreach in the event of lapses.</li> </ul>
S4	Intensity of Services	1 – 5 2	The median weekly intensity of face-to-face service time spent per member was under 46 minutes based on ten member records. The	<ul style="list-style-type: none"> <li>The ACT team should provide members an <i>average</i> of two hours of face-to-face contact weekly. Work with staff to identify</li> </ul>

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			<p>average weekly service time per member ranged from less than six minutes, to nearly 334 minutes.</p> <p>In ten member records, 13% of all notes document 23 minutes of service, and about 21% document 25 minutes. Some staff document medication observation and home visit contact in two notes totaling ten minutes. Other staff document one note for 23 or 25 minutes when providing medication observation.</p>	<p>and resolve barriers to increasing the average service time delivered. Ensure services are accurately documented.</p> <ul style="list-style-type: none"> <li>Evaluate how the team can engage or enhance support to members who receive a lower intensity of service. Documented service time is significantly higher for some members, than for others.</li> </ul>
S5	Frequency of Contact	1 – 5 2	The median weekly face-to-face contact for ten members was 1.6 based on records. Most members received less than two contacts per week, on average, over a month time frame. Only members receiving medication observation averaged more than four weekly contacts.	<ul style="list-style-type: none"> <li>Increase the frequency of contact with members, preferably averaging four or more face-to-face contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact.</li> </ul>
S6	Work with Support System	1 – 5 2	<p>The ACT team has infrequent contact with informal (i.e., natural) supports. Staff estimates between 50-53% of members with informal supports. One staff said that the team is in contact with informal supports, on average, about weekly. Another staff reported contact occurs at least twice monthly, on average. During the program meeting, staff discussed recent or planned contact with informal supports, for 12 members.</p> <p>Two members interviewed said that staff did not contact their natural supports. One member said that staff made occasional contact with their natural supports over the course of many years. Another member was unsure if staff made contact with their natural support.</p> <p>In ten records, over month period, staff documented six contacts with informal supports.</p>	<ul style="list-style-type: none"> <li>The team may benefit from further training on strategies to assist members in building and engaging natural supports. Discuss with members the benefits of involving their supports in their treatment.</li> <li>Educate informal supports about how they can support members' recovery. For example, assist them to identify community-based activities they can engage in with members. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or model use of recovery language.</li> <li>Monitor accuracy of documentation of contacts with informal/natural supports in the member records. Document contacts with informal supports when they occur.</li> </ul>

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			For one member, staff documented five contacts with informal supports to coordinate service. Staff made one phone contact with a natural support for a member. For another member, two contacts occurred with individuals unknown to staff, at the member's home. It was not clear if these were natural supports.	
S7	Individualized Substance Abuse Treatment	1 – 5 4	<p>Staff reported that the team serves 47 members with co-occurring diagnoses. One SAS is assigned 24 and the second SAS is assigned 23 members. Staff said that one SAS provides individual treatment to 15 members and the second SAS provides individual treatment to 13 members. Staff reported one to three weekly individual sessions, each lasting from 28-35 minutes, occurs with those members.</p> <p>Individual treatment was discussed during the team meeting. Examples of individual treatment were found in some member records. One member received four sessions and one member met with an SAS four times over a month period. The records were representative of the team; six of the ten members in the sample have a substance use diagnosis. A sample of 20 member calendars were collected, some include citations to individual treatment. Based on the calendars, an SAS made weekly contact with two applicable members during September 2019.</p>	<ul style="list-style-type: none"> <li>Staff should offer individual treatment to members with co-occurring diagnoses. Explore training on strategies to engage members in substance use treatment.</li> <li>Work to increase the time spent in individual sessions so that the average time is 24 minutes or more, per applicable member.</li> <li>Monitor member participation in individualized substance use treatment through the SASs to gauge duration and frequency.</li> <li>Consider reviewing documentation of individual treatment during supervision with SASs to ensure documentation provides sufficient detail and that services align with the member's stage of change and stage of treatment.</li> </ul>
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Examples of group treatment were found in sample records. Based on sign-in sheets, over a month time frame, about 13% of members with a substance use diagnosis attended group at least once. The majority of participants in the identified co-occurring treatment groups do not have an	<ul style="list-style-type: none"> <li>Engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring group.</li> <li>Ensure groups are structured to provide</li> </ul>

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			<p>identified co-occurring diagnosis and their attendance is not factored for this item.</p> <p>Interviewees offered dissimilar descriptions of where groups occur. One staff said that two groups occur at the clinic and one is community-based. Other staff reported that two groups occur in the community and one at the office. Staff said that the community groups are held at in an ACT affiliated residence where five members reside. One meeting at the off-site location is for the tenants of the home. The second meeting is open to all ACT members. ACT staff said that the tenants of the house like holding the group at their home.</p>	<p>treatment to the population of members with co-occurring diagnoses. Offer groups specific to members with co-occurring diagnoses.</p>
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	<p>Staff said that the team draws from Dartmouth Psychiatric Research Center (PRC) Hazelden resources including: <i>Integrated Dual Disorders Treatment (IDDT)</i>, <i>IDDT Recovery Life Skills Program</i>, and <i>Illness Management and Recovery (IMR)</i>. It does not appear that the program adopted Enhanced Illness Management and Recovery (E-IMR), where IDDT and IMR strategies are synthesized to treat individuals with co-occurring diagnoses. On Omega ACT, it appears IMR and Recovery Life Skills Program materials are primarily used to treat a cross-section of members.</p> <p>The majority of members who participated in the identified co-occurring treatment groups were not found on the list of members with an applicable diagnosis. For example, one group sign-in sheet was titled as IDDT, with the topic of IMR. The group was well attended, but only four of the 14 attendees were identified with co-occurring diagnoses. IMR is a proven beneficial approach to treatment, but does not replace a comprehensive</p>	<ul style="list-style-type: none"> <li>• Offer groups specific to members with co-occurring diagnoses.</li> <li>• Consider noting applicable members' stage of treatment on the team meeting log. The SASs may be tasked with updating the team and log when changes occur. It may help staff to match interventions with members' stages of treatment.</li> <li>• Review with staff to ensure accurate documentation of services on treatment plans. For example, referencing substance use treatment by an SAS, and staff activities based on a member's stage of treatment. Consider discussion of example service plans during group SAS supervision.</li> </ul>

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			<p>co-occurring treatment model.</p> <p>It is not clear how the team is updated on members' stages of change so staff can align their interventions. Staff did not discuss members' stages of change during the meeting observed. The information is not included on the <i>Omega Team Meeting</i> log, but for some members, their status was noted as maintaining recovery.</p> <p>Staff affirmed that the team uses medication-assisted treatment (MAT) and gave examples of medications prescribed. Staff gave examples of recent harm reduction efforts and report receiving IDDT training. Based on records, some treatment plans address substance use, groups and/or individual SAS service. Staff said that the team does not directly refer to Alcoholics Anonymous (AA) or similar groups, but will assist members to access those supports if requested. Staff said that the team occasionally refers members for medical withdrawal management and gave examples when it may be indicated for certain substances.</p>	
S10	Role of Consumers on Treatment Team	1 – 5 4	Some interviewees were unsure if there is a staff with direct lived experience of mental health recovery on the team. Staff said that a person with lived experience usually fills the Peer Support Specialist (PSS) position, which is vacant. Some interviewees said there is a staff on the team with lived experience who shares aspects of their lived experience, when appropriate. One member said it would be nice to know if a staff with lived experience worked on the team.	<ul style="list-style-type: none"> <li>Ideally, the team is staffed with one or more individuals with personal lived experience of psychiatric recovery. Confirm member perspective is represented on the team. Educate staff and members about the role of staff on the team who have disclosed lived experience.</li> </ul>
<b>Total Score:</b>		<b>4.04</b>		

**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	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	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	5
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	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	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	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	4
<b>Total Score</b>	<b>4.04</b>	
<b>Highest Possible Score</b>	<b>5</b>	