ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 15, 2021

To: Peggy Chase, President and CEO

From: Karen Voyer-Caravona, MA, LMSW
Kerry Bastian, RN
Fidelity Reviewers

Method

On January 19 – 20, 2021, Karen Voyer-Caravona and Kerry Bastian completed a review of the Terros 51st Ave Health Center's 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.

The ACT team is operated by Terros, a comprehensive healthcare organization, integrating behavioral health and primary medical care. The ACT team is located at the 51st Ave Recovery Center, 4316 N. 51st Avenue in Phoenix, sharing space with supportive teams, as well as the Ladders substance abuse treatment program.

Due to the COVID-19 public health emergency, it was determined that the record portion of the review should be documentation for a period prior to the public health emergency. Reference in this report to the member records reviewed and related documentation are for the period prior to the public health emergency. Due to the public health emergency, the review was conducted remotely, using video or phone contact to interview staff and members. Federal, State, and local government guidance regarding contact with others outside individuals' homes has varied per the positivity rates. Some agencies impose their own guidance which may be more restrictive relating to contact with others.

The individuals served through the agency are referred to as "clients" or "members", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used. Groups at the 51st Avenue Recovery Center are referred to at the clinic as "classes" however, for consistency across reviews, the term "group" will be used.

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

- Observation of the January 19, 2021 ACT team meeting via telephonic and videoconference platform;
- Individual interview with the Team Leader/Clinical Coordinator (CC);

- Individual interviews with a Substance Abuse Specialist (SAS), the Employment Specialist (ES), and the Rehabilitation Specialist (RS);
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Review of agency documents including: *8 Week Engagement chart*, *8 Week Outreach tracking tool*, *51st Ave ACT Team Welcome Packet*, RBHA developed *ACT Eligibility Screening Tool*, *ACT Contact and Fidelity Guidelines*, ACT CC encounter report for December 2020, resumes and training transcripts for the SAS, ACT Counselor (AC), ES, and RS, list of clinic groups, and SAS and AC calendars for December 2020.

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 team has a member/staff ratio of 9:1, with 11 staff, excluding the Psychiatrist, serving 98 members at the time of the review.
- The ACT team is fully staffed to serve up to 100 members; with all specialty areas filled, the ACT team is well leveraged to provide nearly all behavioral health services.
- The ACT team has full responsibility for 24-hour crisis services, seven days a week. Staff rotate coverage of on-call duties weekly, have an assigned on-call back up, and provide on-site response.
- The ACT team provides time-unlimited services and expects to graduate less than 5% of members in the next 12 months.

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

- Assess the job duties and responsibilities of the Team Leader/Clinical Coordinator with the goal of ensuring 50% of time spent providing direct, in-person member services. Direct member services can include support in mental health court, providing counseling psychotherapy, on-site crisis response, home visits with the Psychiatrist, and live supervision and mentoring specialists in provision of care delivered in the community.
- Train and empower vocational staff to function in their area of specialization. Member records showed vocational staff operating primarily as case managers rather than within the vocational specialization, assisting members with competitive employment goals.
- Over ten percent of members are residents in staffed or semi-staffed locations. Assist members in obtaining safe and affordable independent housing and provide necessary housing support to retain tenancy.
- Provide ongoing training and clinical oversight to all staff in full implementation of the co-occurring treatment model and ensure co-occurring disorders treatment is clearly referenced in service plans and documentation of services delivered to members with the co-occurring disorders diagnosis. Substance Abuse Specialists and other staff primarily responsible for delivering substance use treatment

should be cross-training other specialists in the co-occurring model so that all staff have a common language regarding substance use treatment and recovery and actively engaging members in those goals.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review the ACT team serviced 98 members for a member/staff ratio of nearly 9:1, excluding the Psychiatrist.	
H2	Team Approach	1 – 5 3	Per a review of ten randomly selected member electronic records, 60% of members saw more than one ACT staff in a two-week period. Several records showed that of those members that had contacts with multiple staff in the two-week period, the other staff was the Psychiatrist or a nurse, suggesting a traditional case manager style contact strategy. Though staff interviewed reported having paperwork caseloads only and rotating contact assignments weekly, members interviewed spoke of only seeing one staff in addition to the nurse or doctor during the last seven days before the review.	• Increase the percentage of members seen by more than one staff member in a two-week period, with a goal of 90% or more. Consider strategies such as a zone coverage system or a rotating coverage schedule to increase diversity of member contacts with staff. • Rather than functioning as case managers, train and empower specialists to function within the area of their specialization. Staff should be making face-to-face contacts responding to goals and objectives identified on member service plans.
H3	Program Meeting	1 – 5 5	The ACT team meets four times weekly, Monday through Thursday. At the meeting observed by video and telephonic platform, the CC appeared to lead the meeting, and most ACT staff were in attendance. Some staff such as the SAS and the Psychiatrist attended by remote means, although both were active and engaged participants. Staff reported on recent contacts with members, their natural supports, and/or their guardian. Upcoming appointments, needs, and plans for outreach were discussed. All members were reviewed.	
H4	Practicing ACT Leader	1 – 5 3	The reviewers were told that the ACT CC provides direct care 40% - 50% of the time through activities such as during home visits for medication observation and missed appointment follow up,	• Increase face-to-face member contacts to 50% of time. Practicing ACT leaders can engage in a range of member care needs including providing

			providing Spanish translation. It was reported that the public health emergency has had no impact on the CC's ability to provide face-to-face member services. This could not be substantiated either by the record review or the CC's encounter report for December 2020. The record review showed only two brief member contacts at the clinic. The CC's encounters for the month of December were not useful in estimating the CC percentage of time providing direct member care. Some contacts listed were telephonic; the report also showed documentation of member staffings in the team meeting and could not be readily distinguished from actual face-to-face contacts. During the team meeting observed by the reviewers, the CC reported several face-to-face member contacts.	counseling/psychotherapy, facilitating or co-facilitating co-occurring groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffings, shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery. • The CC and the agency should identify any administrative functions not essential to the CC's time that could be performed by the program assistant or other administrative staff. • Given the importance of the CC and their role on the team, ensure that this position is consistently filled by appropriately trained staff who deliver direct care services to members.
H5	Continuity of Staffing	1 – 5 4	The ACT team experienced an attrition rate of 25% (n=6) in 24-month period before the review. Positions experiencing the greatest turnover were those of the Peer Support Specialist and those providing substance use treatment, the SAS and the ACT Counselor (AC).	• Continue efforts to retain qualified staff to reduce turnover rate to no more than 20% in two years to promote therapeutic relationships, staff cohesion, and for maximizing the benefits of specialty training and other professional development efforts. • Given the low rate of staff turnover in the last 12 months, the agency and the RBHA may wish to explore factors that may have contributed to staff retention.
H6	Staff Capacity	1 – 5 4	The ACT team had a total of 6 staff vacancies in the 12 months before the review period for a capacity rate of 94%. The vacancies were experienced entirely between the months of January and June 2020 and were in the positions	• Hire and retain qualified staff to maintain a staffing capacity of 95% or greater.

			of ACT Specialist (AS) and Independent Living Specialist (ILS).	
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a full-time Psychiatrist who is wholly dedicated to the team's 98 members. The Psychiatrist works four, ten-hour days, Monday through Thursday and attends the daily team meeting providing both an educational component and seeking team input, as demonstrated at the team meeting observed by the reviewers. Due to the public health emergency, the Psychiatrist primarily provides care via videoconference or telephonically, facilitated by ACT specialists. Before the emergency declaration, the Psychiatrist saw members in the clinic and in the community. It was reported to the reviewers that the Psychiatrist can still see members in their homes by virtual means. Staff interviewed spoke highly of the Psychiatrist, describing her as solicitous of their input, helpful with treatment recommendations and providing an educational component to team meetings, and accessible via text and phone after hours and on weekends. One staff remarked feeling comfortable calling the Psychiatrist directly for guidance or asking questions about diagnosis or medications. Members interviewed also spoke positively of the Psychiatrist, all describing her as a good listener.	
H8	Nurse on Team	1 – 5 5	The ACT team has two full-time Nurses. The Nurses provide care both in the community and in the clinic. Both work four, ten-hour days and attend all team meetings on their scheduled days. Staff reported that the Nurses are easily accessible by phone or text, including after hours and on weekends. Staff said the Nurses provide a full range of nursing care from ordering and distributing medications, coordinating care with	

			primary care providers and medical specialists, providing members with medication and wellness education, preparing medisets and giving injections. The records reviewed showed Nurses delivering services in the home and conducting community-based outreach to members who missed appointments.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has an SAS and an ACT Counselor to provide substance use treatment services to 56 members identified with co-occurring disorders (COD). The SAS has been in role for about a year and a half and has continuous ACT experience since 2007, working in other specialty positions. Before assuming the role, the SAS provided part-time coverage for substance use groups. A review of training transcripts show that the SAS completed some Relias trainings in *Cognitive Behavioral Therapy for Substance Use Disorders* in 2019 and 2020. The SAS also completed a team training in December 2020 in *Integrated Dual Disorders Treatment (IDDT)*, but it was not clear who provided the training. The AC earned Master's degrees in both Professional Counseling and Forensic Psychology and has been providing substance use treatment on the ACT team for 14 months. The AC did not have previous experience in substance use treatment but does have over a year's experience working with adult behavioral health recipients between 2015 and 2016. A review of the AC's training transcripts shows numerous trainings in substance use treatment, including *CBT Basics*, *Co-Occurring Disorders and IDDT Basics*, *Coping Strategies for Co-Occurring Disorders*, and *Integrated Dual Diagnosis Treatment Primer*.	• Ensure both SAS and the AC receive ongoing training and clinical oversight in dual disorders treatment. Training in an evidence-based COD model such as Integrated Dual Disorders Treatment would position both specialists to provide cross training to the entire team for a shared understanding to guide the team's approach to substance use treatment.

H10	Vocational Specialist on Team	1 – 5 4	The ACT team has two vocation staff, an ES and an RS who have been in their assigned roles for four years and 14 months respectively. Both the ES and RS had introductory level trainings in employment and rehabilitation, and disability benefits between 2020 and 2015. Records reviewed and interviews suggested, however, that both staff, though providing a considerable amount of direct, community-based care, function primarily as general case managers. Members interviewed appeared to hold the ES in high regard but did not associate either the ES or the RS with employment. Although in the morning meeting observed by the reviewers, several members were identified as working, it was not clear to what extent either vocational staff provide direct engagement in vocational services. Interviews indicated that staff may not be adequately trained or mentored in evidence-based supported employment principles, may lack knowledge of strategies for helping people with SMI manage symptoms and problem behaviors in integrated work settings, and may not be fully aware of the role of competitive work in recovery. It was reported some members are referred to external providers for work adjustment training (WAT).	• Vocational staff may benefit from direct mentoring and targeted training in directly supporting people living with serious mental illness (SMI)/COD in finding and retaining employment in integrated settings. Work in integrated settings is recognized as an essential part of recovery, supporting positive outcomes such as improved self-esteem, better control of psychiatric symptoms, and life satisfaction attained through participation in the community. Technical assistance and/or consultation in ACT team Employment and Rehabilitation Specialist roles is recommended.
H11	Program Size	1 – 5 5	The ACT team has 12 full-time staff serving the team's 98 members for optimal diversity of program coverage. All specialty roles are filled.	• Match disciplinary background and demonstrated skill set with specialist roles when considering future hiring decisions.
O1	Explicit Admission Criteria	1 – 5 4	The team reports to following explicit admission criteria. The CC screens potential members for admission; the SAS and RS also sometimes conduct screenings. Those referred and found to be appropriate and interested in joining the ACT team are staffed with the entire team, including the Psychiatrist, and admitted upon consensus. The	• Ensure that all ACT staff can clearly articulate and understand the ACT team's admission criteria.

			criteria provided to the reviewers was created by the RBHA. Staff reported no pressure to accept inappropriate referrals, although not all staff interviewed appeared comfortable with describing qualifying diagnostic criteria or the target population.	
O2	Intake Rate	1 – 5 5	Data provided the reviewers showed that ACT admissions (n=3) for the six months before the review were well within the appropriate range.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management services, the ACT team has full responsibility for psychiatric services, counseling/psychotherapy services, and substance use treatment services. Records for a period before the public health emergency declaration showed few substance use treatment services provided and some records of members with the co-occurring diagnosis lacked goals and/or recommendations related to substance use treatment. However, SAS and AC calendars provided for December 2020 showed delivery of individual substance use counseling and substance use treatment groups. Full credit could not be given for employment services. Records reviewed showed no documented efforts to offer or engage members in employment services. One record showed a member repeatedly stating a desire for employment, but no engagement or services were offered. In the team meeting observed by the reviewers, the desire to avoid health risks associated with the public health emergency was cited as reasons that members declined employment engagement. Documentation did not show how vocational staff were helping members to sustain jobs or offering to do so. Additionally,	• Continue efforts to assist members in obtaining safe and affordable independent housing and provide necessary housing support to retain tenancy. • ACT vocational staff should embrace evidence-based practice principles of competitive employment for SMI and co-occurring members. Ensure that staff receive training, mentoring, and oversight in supporting and maintaining member's motivation and enthusiasm for work in integrated settings.

			interviews suggest that some staff apply work readiness criteria and promote the use of brokered work adjustment training programs and sheltered programs. Full credit for housing support could not be given because over 10% of members were reported to be living in residences with some level of staff support.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides crisis services to members 24-hours a day, seven days a week. The on-call phone is rotated among specialists weekly, and the rotation includes a back-up. The on-call staff will go onsite for further assessment if members express suicidal ideation. Staff will file a petition if the member is a danger to self or others and will not go inpatient voluntarily. Members are provided the ACT crisis number as well as staff cell phone numbers. Natural supports are also provided the crisis number and urged to call the team if concerns arise rather than trying to admit the member on their own.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Per a review with the ACT CC, the ACT team was directly involved with 90% of the last ten inpatient psychiatric hospital admissions. One member was petitioned by a family member without the team's knowledge. Staff described the team filing petitions or amendments in all but one of the remaining admissions. In one admission involving a petition, the team had previously filed the petition due to the member missing appointments and not taking medications as prescribed when the police picked up the member for an unrelated matter. Police transported the member to Community Bridges; CBI notified the team immediately and coordination of care commenced. Staff reported	• Continue efforts to educate hospitals, members, and members' informal supports about the benefits of involving the ACT team in psychiatric admissions.

			that due to the public health emergency most hospitals only allow the team to drop the member and any accompanying paperwork off for admission. Some facilities allow ACT staff to be present at admission, but do not permit staff to accompany the member to the unit. Hospitals do not allow hospital visits while members are inpatient, and do not hold in person staffings. Staffings are conducted by teleconference. Coordination of care with inpatient staff is conducted over the phone or email.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff said discharge planning begins at admission with exchange of contact information and delivery of necessary psychiatric notes and medications list. The ACT team and inpatient teams staff at least weekly to plan aftercare, especially where the member will be discharging to, either return to home or an appropriate placement. The ACT and inpatient Psychiatrists also confer. A discharge date is determined, and a staffing takes place. Since the public health emergency, the discharge staffing usually occurs telephonically. In most cases the ACT team transports the member back to where they live, or if the member is believed to have been exposed to or tested positive for the COVID19 virus, arranges for a cab to transport the member while following to their destination in a separate vehicle. Staff assist the member in filling any prescriptions and collecting groceries or other necessary items for their return home or where they will be staying. The member either meets with the Psychiatrist that day or within 72 hours and with the Nurse within the week, and staff are supposed to conduct face-to-face follow-up contact for five days.	• Continue efforts to educate hospitals, members, and member informal supports about the benefits of involving the ACT team in psychiatric discharges. • Identify and find solutions to possible gaps in coordination of care between ACT team staff and inpatient psychiatric facilities that result in members being discharged without notification or direct involvement of the ACT team.

			Per a review with the ACT CC, the ACT team was directly involved with 80% of the last ten inpatient psychiatric hospital discharges. In one case the facility coordinated the discharge with the member's significant other rather than the team, despite a previous staffing with the team. The team did not know about the discharge until it was reported to them by the member's significant other. In the other case, the facility called the ACT team to pick up the member for discharge without previous notification due to the member's petition expiring after the member was not transferred to the hospital where mental health court hearing was to have occurred. Staff team reported they were surprised by the discharge.	
O7	Time-unlimited Services	1 – 5 5	Staff reported graduating two members in the past 12 months and anticipate graduating two members in the next 12 months. Staff said that the RBHA guidance is to explore graduation with members who demonstrate stability in the community for at least a year, as evidenced by remaining housed, maintaining employment or engaged in meaningful activity, experiencing neither inpatient psychiatric hospitalization or involvement with law enforcement, being able to self-administer medication without prompting, and attend necessary appointments. Staff acknowledge connection to the ACT team may be a factor in members being able to maintain this level of functioning but will try and work with the member to help them feel comfortable with transitioning to supportive level of care.	
S1	Community-based Services	1 – 5 4	For the period reviewed, ten member records showed that the ACT team delivered community-based services approximately 64% of the time. The range showed an average low of zero community-	• Continue efforts to deliver 80% of face-to-face services in community settings where challenges and learning are the most likely to occur.

			based contacts to an average high of 100%. Most community-based contacts were home visits for medication observation and assessment of member needs in their home environment. Other community-based visits included counseling/psychotherapy, jail visits, support at inpatient discharge, and grocery shopping. Staff interviewed reported that they continue to provide home visits and other community-based contacts, to the extent that members are comfortable, following public health guidance regarding social distancing and masks.	
S2	No Drop-out Policy	1 - 5 5	The ACT team retained greater than 95% of membership over last year. Two members moved out of area out of the area without notifying the team in advance. The team eventually located both members out of state but either they or family members who were with them either refused contact or declined help with referrals. Two other members refused services and rejected all efforts of staff to motivate engagement with the team and services offered. One of those members joined the team as a condition of court-ordered treatment and wanted nothing to do with the team after the court order was removed. Both members were transferred to supportive level of care.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The ACT team has a formal written *8 Week Outreach Engagement* protocol and an *8 Week Outreach* checklist. The protocol relates specific activities that staff should follow during each week, including specific instruction for members who are courted ordered to treatment. The checklist prompts for four outreaches and dates of contact attempts for each of the eight weeks. The checklist also describes a "no show" protocol for	• Ensure documentation of all outreach efforts. Prioritize outreach efforts in the community.

			missed appointments for five days before a member is placed on outreach. Staff interviewed said that the checklist is maintained in a binder that rotates weekly among the specialists, who are responsible for conducting outreach activities during their assigned week. Outreach activities include visiting the member's home, last known address, or frequently visited locations; phone calls and certified letters; contacting natural and formal supports; and contacting shelters, jail, ERs, and morgues. In the team meeting observed by the reviewers, staff talked about outreaches made and planned for the day. Some records did not show follow up calls or home visits for a week or more after missed appointments. One record showed only efforts to engage by telephone with a member who was out of contact and whose significant other was calling about the member's check. The reviewers were told that specialists struggle to complete documentation in a timely manner, instead prioritizing responding to member needs.	
S4	Intensity of Services	1 – 5 2	Per ten member records, for the period of review, ACT staff provided an average of 39.8 minutes of face-to-face member services per week, with an average of 3.72 minutes to an average high of 71.75 minutes. The record review showed that some members were engaged in multiple group services at the clinic with non-ACT staff, which were not included in the calculation. Members interviewed reported having one or two face-to-face contacts within the last seven days with ACT staff. Some members reported going to the clinic less and/or having primarily phone contact with staff due to the public health emergency.	• While following public health guidance, ACT teams should provide an *average* of two hours or more of face-to-face services per week. This is based on all members across the team; some may need more contact and some less week to week based on their individual needs. • Focus on delivering community-based contacts that are individualized and geared toward building skills that help the member achieve goals toward his or her unique recovery vision. Avoid over-reliance on clinic-based -groups.

S5	Frequency of Contact	1 – 5 2	The written *ACT Contact and Fidelity Guidelines* provided to the reviewers state that members should receive four face-to-face contacts per week. Staff reported that the team continues to prioritize face-to-face contacts in the community during the public health emergency. Per interviews, some staff primarily work remotely and/or limit time at the clinic per public health guidance for people who may be or live with those who are medically at risk. While staff interviewed reported more reliance on the telephone to check on members, home visits continue to be provided by staff who feel comfortable doing so but most meet outside, while also practicing social distancing and other recommended accommodations to reduce risk. One staff discussed the importance of in-person contacts to adequately assess member status and needs, also noting the contact served to minimize the impact of isolation. Per member records for the period reviewed, members received an average of 1.63 face-to-face contacts with ACT staff per week, with a low average of .25 contacts per week to a high average of 3.75 contacts per week. Many contacts focused on environmental and needs assessments and medication observations; many contacts appeared to be brief, unscheduled contacts at the clinic when members were there for appointments with the Nurse or Psychiatrist or to attend a group.	• The ACT team should strive to provide members with an *average* of four or more contacts per week. Members may receive more or less than four contacts depending on needs and goals, but the average of all members should be four or more. Contacts should occur in community settings whenever possible and should be purposeful, person-centered, and recovery oriented. • A renewed emphasis on specialty practice may lead to improvement in frequency of contact.
S6	Work with Support System	1 – 5 3	Per a review of ten member records, the ACT team has an average of 1.4 contacts with members' natural supports in a month period. During the meeting observed by the reviewers, staff reported contacts with natural supports, as well as plans to	• Increase contacts with members' informal support systems to four or more contacts per month; regularly revisit with members the benefits of allowing communication between ACT staff and informal supports.

			follow up with natural supports for such things as outreach and appointment reminders. Staff report that approximately 70% - 74% of members have at least one natural support. Staff said that about 40% of members on the team live with family. Some records showed contact with natural supports at home visits and when natural supports accompany members to the clinic for appointments, as well as by phone and email. One staff described family input as important in assessing member needs and functioning. Staff also said family may benefit from contact with staff due to the burden of caregiving. Some members interviewed said that staff sometimes talk to their natural support.	• Consider helping members expand their definition of informal supports to consider unpaid helpers other than family such as clergy, neighbors, and members of the peer community, such as relationships at peer-run organizations. • Continue to regularly educate members on the importance of developing and including an informal support system in their treatment plans; maintain current release of information forms for contact with informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 4	It was estimated by staff interviewed that, of the 56 members with a co-occurring disorder, about 20 received at least one formally structured substance use counseling session in the month period before the review, in meetings ranging from seven minutes to 60 minutes. Most sessions occurred outside of members' homes to accommodate public health guidance. SAS and AC electronic calendars for the month of December 2020 showed 15 members receiving an average of two individual substance use counseling sessions. Because time spent was not visible for all entries, the average amount of individual substance use counseling delivered could only be estimated and appeared to be less than 24 minutes for all members with the co-occurring diagnosis. Records sampled including five belonging to members with a co-occurring disorder and showed that one member received multiple counseling sessions, but it was unclear how recent illicit substance use was being addressed; no plans for intervention	• The ACT team should provide at least 24 minutes per week of formally structured individual substance abuse treatment across all members diagnosed with a COD. • Documentation of substance abuse treatment should clearly indicate the member's change stage and the SAS/ACT team plan to assist the member in achieving recovery goals, as well as interventions/stage-wise approaches to encourage movement along the stages continuum.

			designed to raise awareness of substance use and the member's current situation were found.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The ACT team provides two groups weekly at the clinic for members with a co-occurring disorder, Tuesday and Friday, for one hour each. The groups are held in a large room at a social distance and limited to ten members per session. At the time of the review, staff reported that approximately ten members attend each group but that before the public health emergency, attendance was about 13 – 14. The ACT Counselor (AC) facilitates both COD groups, beginning each with a check in with how attendee are doing in their recovery, followed by an open discussion of topic such as trigger and exploration of root causes of use. The groups are not distinguished by stages of change or other criteria. It was not clear what source material the AC uses for COD groups, but the reviewers were told that the SAS, who previously conducted the groups before moving to remote work after the public health emergency declaration, used a manual, *100 Integrative Activities for Mental Health and Substance Abuse Recovery* (C. Butler, 2001), to break the ice and build comradery. The reviewers were also provided a copy of a substance use client manual for published by the Substance Use and Brain Injury Project, but it was not clear who used the manual or in what context. The reviewers were told the manual was passed down from a previous SAS. It is not clear how closely either manual aligns with an evidence-based co-occurring model.	• ACT staff should collaborate to increase participation in substance abuse treatment groups to 50% of members with a COD. • Consider structuring groups to target ACT COD members in early and later change stages so that discussions and interventions more relevantly align with their needs and concerns. • It is recommended that ACT co-occurring groups be closed, open only to ACT members whose treatment and support needs may be more complex than those assigned to a lower level of care. ACT SAS time spent providing services to other members, outside of the team, can impact whether SAS staff are fully available to ACT members (i.e., H9, Substance Abuse Specialist on Team). • Consultation or technical assistance is recommended to determine how closely manual and other source materials align with evidence-based practice co-occurring disorders treatment approaches, such as Integrated Dual Disorders Treatment (IDDT).

			A review of group sign-in sheets for December 2020 showed that slightly over 5% of all members with the co-occurring diagnosis attended at last one substance use treatment group. Most members on sign-in sheets were not identified on the co-occurring disorders roster provided the reviewers. A flier provided the reviewers with a list of all groups offered at the clinic showed a Relapse Prevention group was offered by a staff not assigned to the ACT team. It is unknown if that group is designed for Action and Maintenance stage members with the COD diagnosis or if any ACT members attend that group.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The ACT team appears to mix traditional approaches with an awareness of some co-occurring treatment methods. The reviewers observed that ACT staff, in interviews and the team meeting observed, did not use stigmatizing language when discussing members' substance use. It is not clear, however, how well grounded the team is in evidence-based co-occurring principles. The AC has had numerous online trainings in substance use and co-occurring disorders treatment (including some in IDDT) but no specific information was provided on who provides clinical oversight in this area or how often. The reviewers were told that the AC provides clinical oversight to the rest of the team in dual disorders treatment. However, not all staff interviewed appeared familiar with COD principles beyond stages of change or harm reduction. Most staff interviewed were not very familiar with or could not easily describe stage-wise approaches that align with stages of change. Further, service	• The entire team would benefit from ongoing training and clinical oversight in the co-occurring model. Committing to an evidence-based practice framework such as IDDT would provide all ACT team staff a shared understanding of dual disorders principles. All specialists should be regularly offering or providing stage-wise, recovery oriented, substance use engagement to members with a COD. Consultation and technical assistance in the co-occurring model and Motivational Interviewing are recommended.

			plans show few needs, objectives, or action plans reflecting a stage-wise approach.	
S10	Role of Consumers on Treatment Team	1 – 5 3	Per interview with ACT staff and members, no staff on team was identified as a person with the lived experience of psychiatric recovery. It was reported that the PSS has indirect experience of recovery, the nature of which could not be determined. One staff noted that the PSS's relationship to recovery was a private matter and was unaware of whether or not the PSS self-disclosed to members or other staff. Members interviewed could not identify anyone on team with lived experience. Although it was reported that the PSS functions as full member of the team, the reviewers could not determine from interviews if that staff had a personal story of psychiatric recovery. It was not clear from interviews that all staff view peers as able to serve as full members of the team, with similar levels of autonomy.	• Ideally, the PSS position should be filled by a person with the lived experience of psychiatric recovery. Further, the PSS should use appropriately timed and client-centered self-disclosure to inspire hope and model recovery. Additionally, the PSS role is designed to lend the team a peer perspective, to be empowered to educate other specialists on the recovery process, and to challenge instances of stigmatizing attitudes and biases that may undermine member motivation for treatment. Peers should be considered team assets. Some ACT teams actively recruit peers for any specialty role on the team for which the necessary training, expertise, or credentialing.
Total Score:		3.96		

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	5
4. Practicing ACT Leader	1-5	3
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	4
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

5. Responsibility for Hospital Admissions	1-5	4
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	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	3
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	3
10. Role of Consumers on Treatment Team	1-5	3
Total Score	3.96	
Highest Possible Score	**5**	