ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: June 10, 2022

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AHCCCS Fidelity Reviewers

Method

On May 3 - 4, 2022, Kerry Bastian and Nicole Eastin completed a review of the Copa Health Gateway 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 Copa Health Gateway ACT team transitioned from Chicanos Por La Casa (CPLC) Centro Esperanza ACT team in July 2020. Copa Health provides a multitude of services throughout the region, including integrated healthcare, permanent supportive housing, residential services, and counseling, among other services to a range of persons with intellectual developmental disabilities and/or mental health conditions.

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

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

- Remote observation of an ACT team program meeting on May 3, 2022.
- Individual interview with the ACT Clinical Coordinator.
- Individual interviews with two Substance Abuse Specialists (SAS), Rehabilitation Specialist (RS), Housing Specialist (HS), ACT Team Staff, and a Counselor assigned to the team.
- Individual phone interviews with three members participating in ACT services with the team.

- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and
- Review of documents: *Mercy Care ACT Admission* and *Exit Criteria Screening Tool, Clinical Contact Guidelines*, *Gateway ACT Handout*, ACT member roster, Co-occurring disorder diagnosis member roster, Clinical Coordinator productivity report, resumes and training records for VS, SAS and CC, sample of SAS's calendar for one week, and sign in sheets for substance use treatment groups for the month of April 2022.

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 review. 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:

- Program meeting: Team meets four days a week and reviews all members each time.
- Psychiatrist on the team: The ACT Psychiatrist is fully dedicated to the ACT team, with no outside responsibilities, and accessible to staff and members, including providing weekly home visits.
- Explicit admission criteria: The ACT team has explicit admission criteria; the CC and other staff conduct screenings of referrals and report no outside pressure to admit members to the team.
- Intake rate: The ACT team admits members at a low rate to maintain a stable service environment.
- Team Approach: The entire team shares responsibility for each member, with members seeing more than one team member in a two-week period.

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

- Continuity of staffing: Several positions on the team (Nurse, Employment Specialist, Peer Support Specialist, and Independent Living Specialist) are vacant. Filling vacant positions as soon as possible helps to reduce burden on team staff and ensures members do not experience disruption in service due to lack of staff.
- Community-based services: Increase in-person contacts in the community directly supporting members to 80% or more. ACT services should occur in the community where challenges are more likely to occur and where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural non-clinical setting.
- Increase the intensity of service and frequency of contact as it relates to members individual needs and preferences. Higher frequency of contact correlates to improved outcomes for ACT members. Work with staff to identify and resolve barriers to increase intensity of service and frequency of contact.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 - 5 4	At the time of the review there were seven full-time equivalent (FTE) staff on the team, excluding the Psychiatrist. It was reported that there are 95 members on the team, leaving a member to staff ratio of 14:1. A counselor is assigned to the team but only attends the program meeting once a week, therefore, this staff is not considered for this item.	• Ensure necessary staffing for a member to staff ratio of no greater than 10:1, excluding the Psychiatrist. • Continue efforts to hire and retain experienced staff. Small caseload size ensures adequate intensity and individualization of services and minimizes the potential burden on staff.
H2	Team Approach	1 – 5 5	Staff interviewed reported using a weekly rotating assignment of zones to ensure members are exposed to diversity of staff. The medical staff are not included, nor are the SASs. Per review of ten randomly selected member records, for a two-week period, 90% of members received in-person contact with more than one ACT staff. Members interviewed reported seeing more than one staff in a two-week period and were able to name numerous staff recently seen from the ACT team.	
H3	Program Meeting	1 – 5 5	Per staff report, all members are discussed in the program meeting that is held four days a week, Monday, Tuesday, Thursday, and Friday. The team meets on Wednesdays to discuss members' needs more in-depth and update treatment plans. All staff are expected to attend on days they are scheduled to work, including the Psychiatrist. During the meeting observed, staff reviewed all members, reported stages of change for members with co-occurring disorders, individual housing status and needs, employment efforts, and natural supports. The CC reports the meeting is very fluid and all members are reviewed for the past 24	

			hours with tracking from the administrative assistant.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated delivering in-person services to members 50% of the time. Per report, services are provided to members in the community, the office, by email and over the phone. Reported activities include coordination of care with guardians, natural supports, inpatient teams including attending scheduled staffing's and discharging members from inpatient settings, independent living skills, case management, facilitates a weekly group for ACT members, conducts home visits, and engages with members when at the clinic. Based on review of the CC's productivity report provided, the CC provides direct in-person services less than 10% of the time over a recent month timeframe. Two examples of in-person services delivered by the CC were documented in the ten records reviewed, in addition were several examples of coordination of care with a guardian, inpatient team, residential facility, and the ACT Psychiatrist was documented in one member chart. *The fidelity tool does not accommodate delivery of telehealth services.*	• Optimally, the CC's delivery of direct in-person services to members should account for at least 50% of the time. Sharing the provision of community-based services will allow for opportunities to observe, train and mentor other staff. • Identify administrative tasks currently performed by the CC that can be transitioned to other administrative or support staff, if applicable.
H5	Continuity of Staffing	1 – 5 3	Based on data provided, ten staff left the team in the past two years resulting in a turnover rate of 42%. Per interview and data reviewed, Nurses were the most difficult to retain. Staff reported that four original staff continue as members of the ACT team since it's development.	• Optimally, turnover should be no greater than 20% over a two-year period. Consistency in staff contributes to team cohesion and enhances the therapeutic relationships between members and staff. • Recruit and seek to retain qualified staff who are aware of ACT staff expectations. Ensure staff receives training and guidance applicable to their specialty position.

				Research shows staff remain in positions longer when supported in their roles.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 80% of staff capacity during the past 12 months. There was a total of 29 vacant positions in the past 12 months. The Employment Specialist position remained unfilled for nine months, while the Rehabilitation Specialist position has been vacant twice, four months each time for a total of eight months of the year.	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually. • Attempt to identify factors that contributed to difficulties retaining specialty positions.
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a full-time Psychiatrist that works Monday thru Friday. The Psychiatrist attends program meetings four times a week and has no outside responsibilities. One day a week, the Psychiatrist sees five to eight members in the community. ACT staff report the Psychiatrist is readily accessible by phone, email, in person and is available on weekends and evenings. Members interviewed reported meeting the Psychiatrist monthly or more often when needed. One member reported "the team's Psychiatrist is always aware, well up to date on the case management stuff as well."	
H8	Nurse on Team	1 – 5 3	At the time of the review, the ACT team had one full-time Nurse that was hired in June 2021, while the other Nurse position is vacant. The Nurse works four, ten-hour days, Tuesday through Friday and attends program meetings on the days they are scheduled to work. Staff reported the Nurse conducts health assessments, administers injections, distributes weekly/monthly medication bubble packs, reviews orders, provides medication education to members and staff, draws labs, and coordinates with primary care physicians,	• Ensure ACT team coverage at two 100% dedicated, full-time Nurses per 100 members. • Continue efforts to recruit and retain a second Nurse to provide consistency and coverage for both the clinic and community-based services·

			hospitals, and pharmacies. Staff stated the Nurse is always accessible and responsive including scheduled days off, if needed, and does not have responsibilities outside of the ACT team. Members interviewed reported meeting with the Nurse monthly at the clinic or at times in their homes.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team is staffed with two full-time Substance Abuse Specialists (SAS). One SAS has been with the team since August of 2020 and has previous experience as an SAS on another ACT team. The second SAS transitioned from the Peer Support Specialist (PSS) on this ACT team to SAS in January 2022, per the resume provided, the SAS has approximately three years of experience facilitating substance use recovery groups including relapse prevention, refusal techniques and harm reduction in a previous position. SASs receive four hours per month of individual supervision from a clinically licensed agency staff. Training records provided for the SAS's showed limited training specific to substance use disorders treatment and co-occurring disorders treatment.	
H10	Vocational Specialist on Team	1 – 5 2	The team has one Vocational Specialist. The Rehabilitation Specialist (RS) joined the team in March 2022. The ES position has been vacant for nine months. Per interviews, and review of training records and resume, the RS has less than one year of experience and little relevant training supporting individuals in rehabilitation or employment services. During the program meeting observed, members' rehabilitation and vocational goals were discussed, and the RS was engaged in reporting on current status and planned contact.	• Fill and maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Ensure that vocational staff receive training in assisting people diagnosed with SMI/co-occurring diagnoses, to find and retain competitive employment. Training should include techniques to engage members to consider employment; job development strategies; the importance of supporting face-to-face employer contacts soon after members express an employment goal; and

				the provision of follow-along supports to employed members. • Support the RS in attending the quarterly vocational meetings provided through the Regional Behavioral Health Authority to learn about resources available in the region and best practices in vocational services.
H11	Program Size	1 – 5 4	At the time of the review, with eight full-time direct staff, the team is less than optimal size to provide staffing diversity and coverage.	• Hire and maintain adequate staffing. Ideally, ten or more staff work on an ACT team. A fully staffed team allows the team to consistently provide diverse coverage; allows staff to practice their specialties which can improve job satisfaction; reduces potential burden on staff; and accommodates the delivery of comprehensive, individualized service to each member.
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. The CC conducts most of the screenings, although all staff are trained on completing screenings. Once a referral is received, the ACT staff reviews information provided and a meeting is scheduled with the potential member to complete the screening. These meetings can include inpatient teams, the member's current case manager, guardians, natural supports, and coordination between the treating Psychiatrist and the ACT Psychiatrist. The screening information is reviewed with the ACT Psychiatrist and makes the final decision if the member is appropriate for the team. Staff indicated if a member is eligible for ACT services, however, has reservations about joining the ACT team, staff will complete up to	

			three screenings with a diversity of staff from the team to provide additional information and answer any questions pertaining to ACT services. The ultimate decision is that of the potential member. Referrals originate from other less intensive teams at Copa Health, community hospitals, and anyone open to services in Maricopa County.	
O2	Intake Rate	1 – 5 5	Per data provided, and reviewed with staff, the ACT team has an appropriate rate of admissions with less than six members per month admitted to the team. The month with the highest rate of admissions in the last six months was October with four new members added to the team roster.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team provides psychiatric and medication services, and substance use treatment services. No members receive psychiatric services outside the ACT Team. The ACT team has two SAS's that provide both individual and group substance use treatment to ACT members. Counseling/psychotherapy for the ACT team members is provided at the clinic and in the community by a Licensed Associate Counselor that is assigned to the team every Friday and meets with eight members. Additionally, two members of the ACT team are engaged in counseling outside of the ACT team. Per observations, records reviewed, and interviews with staff, at least 19% members reside in staffed locations, including Behavioral Health Residential Facilities, Community Living	• Track the number of members in staffed residences. To the extent possible, ACT staff should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team. Optimally, no more than 10% of ACT members are in settings where other social services staff provides support. • Support an integrated team approach by providing additional training in vocational supports that educate the team on the benefits of all ACT staff engaging and directly supporting members with rehabilitation and competitive employment goals rather than engaging them to participate in temporary WAT or employment services with brokered providers. It is beneficial for ACT team staff to be cross trained in specialty areas, so

			Placement), group homes, assisted living, and sober living. At the time of the review, the ACT team had a vacant ES position. Staff report the RS provides support to four members to seek employment and 12 members are competitively employed. However, approximately six members are in a work adjustment training program (WAT), and two members receiving Supported Employment (SE) services with brokered providers.	that all staff can provide individualized services to assist clients in reaching their recovery goals.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour crisis response services to members, rotating on-call weekly between five to six staff, excluding the Nurse and Psychiatrist. The CC reports being the backup on-call should more than one crises occur at the same time. The ACT team provides members with a *Gateway ACT Handout* that includes staff names, positions, phone numbers, emails and the team's on-call and secondary on-call numbers. Members interviewed reported familiarity with the staff contact list and the on-call phone number.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff indicated the team is directly involved in member hospital admissions. During business hours when a member is experiencing an increase of symptoms the member is brought to the clinic to be assessed by the Psychiatrist. If it is determined the member needs inpatient treatment, staff will transport the member to the closest facility and remain with the member throughout the intake process, ensuring the inpatient team has the ACT team's contact information. After hours ACT staff will meet the member in the community to assess. On-call staff can contact the Psychiatrist or CC for next steps. In	• Work with members and their support networks to discuss how the team can support them in the event of a psychiatric hospital admission, especially if members have a history of hospitalization without team support. Ideally the ACT team should be involved in at least 95% of all psychiatric hospital admissions. • Increasing member engagement through a higher frequency of contact and intensity of service may offer staff more opportunities to assess and provide interventions to reduce psychiatric hospitalizations, or to

			the event it is determined the member needs inpatient treatment, staff will transport or arrange transportation to the nearest inpatient facility. Based on data provided, and reviewed with ACT staff, of the ten most recent psychiatric hospital admissions, the team was directly involved in 70% of the admissions. Verbal review with leadership of the additional admission requested did not support the documentation in the reviewed record. Two other members self-admitted without contacting the team prior to admission.	assist in admissions when indicated. This may also offer more opportunities for staff to engage and build rapport with natural/informal supports· • Ensure all attempts, contacts and coordination of care are documented in the member records.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff stated the team is directly involved in all psychiatric discharges unless the member leaves against medical advice, or the team is not notified of the discharge. Discharge planning begins upon admission. The team coordinates staffings with the inpatient team weekly either by phone or videoconference. The CC reported often taking the role of coordinating and communicating with inpatient teams to lighten the load for Case Managers. Members are discharged from inpatient settings and brought to the clinic by ACT staff or third-party transportation. Staff reported third-party transportation was utilized more often during the height of the public health emergency and is seldom utilized now as staff can transport members. The ACT team follows a five-day follow-up hospital discharge protocol which includes in-person contact daily for five days, a minimum of three contacts in the community. The member is scheduled to meet with the Psychiatrist within 72 hours, the Nurse within 10 days of hospital	• Continue efforts to build relationships with inpatient staff and use resources available to advocate for member care. Educate and inform members, inpatient psychiatric hospital staff, and member's natural supports of the availability of the ACT team to assist in the discharge process for members. Some teams provide ACT team business cards to improve coordination of member care or place the team staff names, numbers, and after hours on-call number on the tag of their email signature.

			discharge, and are scheduled with their PCP within in 30 days. For members that readmit within 30 days, the CC, Psychiatrist and Case Manager will meet with the member and evaluate if the service plan needs to be updated for increased service delivery. Based on data provided and reviewed with staff, the team was directly involved in 80% of the discharges. Two members were discharged without the hospital notifying the clinical team. Staff interviewed expressed concern that some hospitals do not value the input from the ACT team and are discharging members prematurely.	
O7	Time-unlimited Services	1 – 5 4	Data provided to reviewers showed that the ACT team graduated ten members in the last 12 months. Staff reported that they anticipate graduating about five to six percent of members in the next year.	• The team should work toward maintaining an annual graduation rate of fewer than five percent of the total caseload.
S1	Community-based Services	1 – 5 2	Staff interviewed reported 80% of in-person contacts with members occur in the community. However, a review of ten randomly selected member records showed a median of 28% of contacts staff had with members occurred in the community. Two members interviewed reported that they see staff mostly at the clinic for appointments or when attending groups. Another member stated staff visit them in their home at least once or twice a week.	• Ideally, 80% or more of services occur in the members communities where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural non-clinical setting. • Shift the focus of service from the office to the community. Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts.
S2	No Drop-out Policy	1 – 5 4	In the 12 months prior to the review, the team retained 94% of members. Two members could not be located and were moved to Navigator status, one member refused services, and three	• ACT teams should ideally retain 95% of the entire caseload year to year. Several factors can impact this number positively including admission policies, consistency in staffing,

			members left the area without a referral or adequate coordinated services prior to move, despite the team's effort to coordinate. One staff reported that ACT services are voluntary and that when members express no longer wanting the service, the team will discuss a lower level of care if appropriate, and the final decision is made by ACT Psychiatrist.	informal/natural support involvement, assertive engagement practices, outreach practices, and taking a recovery perspective with member care.
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff said that when unable to locate members, one staff from the team is assigned to conduct outreach four times per week: two community attempts and two phone calls. Some staff were unsure how many weeks outreach attempts need to be made per the team's policy. Outreach attempts include by telephone, last known address, areas known to the members, and contacting hospitals, jails, the morgue, natural supports, and probation officers. Of records reviewed, one showed the same ACT staff completing one community attempt and one documented call in a week period for a total of six outreach attempts in a three-week period.	• Ideally, outreach should be carried out by multiple ACT staff, allowing them a diverse experience, and documented in the member's record. Provide training to staff on outreach efforts and expectations. • If members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Ensure that community-based efforts occur. Discuss and track these efforts during the program meeting. Consider peer review of documentation to ensure efforts are accurately included in member records.
S4	Intensity of Services	1 – 5 2	Per a review of ten randomly selected member records for a month period before the fidelity review, the median amount of time the team spends in-person with members per week, is 41.25 minutes. Three member records reviewed received more than 130 minutes of ACT service time during the reviewed timeframe. Five records reviewed showed less than 30 minutes of ACT service time during the timeframe. *The fidelity tool does not accommodate delivery of telehealth services.*	• The ACT team should provide members an average of two hours of in-person contact weekly. Intensity may vary based on where the member is at in recovery, but an average of two hours across members on the team should be the goal. • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service.

S5	Frequency of Contact	1 – 5 2	Of the ten records randomly sampled, ACT staff provided an average frequency of two contacts to members per week. Three members charts reviewed had four or more in-person contacts a week. The majority (seven of ten) of those members received two or fewer contacts on average per week over a month timeframe. Two members interviewed stated that they saw staff on average three times a week, but one member reported only one or two times a week.	• Members of ACT teams are not successful with traditional case management and often require more frequent contact to assess current needs and to provide ongoing support. Improved outcomes are associated with frequent contact. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. • Identify and resolve barriers to increasing contact with members. Optimally, members receive an average of four or more in-person contacts a week.
S6	Work with Support System	1 – 5 4	Staff report that approximately 40 - 50% of members have family or other supports that they would like involved in their treatment. Staff attempt at least weekly contact with natural supports via telephone, email, or in-person. Natural support contact is tracked during the program meeting on member calendars. Staff assigned to members for administrative purposes are responsible for contacting natural supports weekly. Based on the ten member records reviewed, the ACT team has contact with natural supports, averaging 2.20 contacts per month. The highest number of contacts in the ten records reviewed was eight in one month, while other records had none. Two members interviewed reported ACT staff having contact with their family. Additionally, unique to this ACT team, staff reported that groups are open to natural supports to sit in and observe. The team also offers a	• Continue efforts to involve natural supports in member care. Increase contact with informal supports to an average of four per month for each member with a support system. As much as possible, contacts should occur during the natural course of delivery of services provided to members. • Ensure that all natural support contacts are documented in members records.

			weekly support group for natural supports on how to best assist loved ones and the supports the ACT team has to offer. Participation in the National Alliance on Mental Illness (NAMI) is encouraged to natural supports and supported by ACT staff.	
S7	Individualized Substance Abuse Treatment	1 – 5 4	Based on records provided, staff interviews, and review of ten member records individual substance use treatment services are regularly offered and provided to members by ACT staff. Staff identified 61 members being diagnosed with a co-occurring disorder (COD) and reported that all 61 meet with SASs each month. The two SASs divide the group in half with each having 30 and 31 assigned members. SASs report that all members get 30 minutes a week of individual counseling in their home. SAS's calendars provided for one week had a total of 38 members on the schedule for weekly individual substance use sessions, however no documentation for amount of time spent in session or if the sessions occurred was provided. SASs are scheduled to work weekends and meet with members that have missed scheduled individual substance use treatment session during the week. SASs report they are not part of the zone coverage rotation but communicate to staff on zone coverage when they will be meeting with individual members. SAS's cited Integrated Dual Disorders Treatment as the treatment model utilized. Of the ten records reviewed, six members had active co-occurring diagnosis with four members records reflecting formal individual substance abuse counseling one to four times a month, lasting between 23 - 28 minutes each. One	• Across all members with co-occurring disorders, an average of 24 minutes or more of formal structured individual substance use treatment should be provided weekly. • Monitor member participation in individualized substance use treatment through the SASs to gauge duration and frequency.

			member had no documented individual counseling, and another was on outreach for a majority of the month and received no individual counseling.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The ACT team reports that groups at the clinic had just resumed in April 2022 after a halt due to the public health emergency. The ACT team currently offers four co-occurring treatment groups a week, divided into a Maintenance/Action and Contemplative/Pre-contemplation groups for members that are stage appropriate. Each group lasts up to an hour. The groups are shared between the two SASs. Additionally, one SAS does a substance use treatment group on Sundays at a local park and reports about 11 members attend weekly. The content of those groups includes triggers in the community, refusal skills, relapse prevention, negative feelings, life skills, harm reduction and social anxiety. Staff interviewed reported that 50 - 80% of members with a co-occurring diagnosis have attended at least one substance use treatment group in the last month. SAS's cited Integrated Dual Disorders Treatment as the treatment model utilized. Review of substance use treatment group attendance sheets for the month prior to the review showed 15 unique members attended at least one substance use group, resulting in 25% of all members with a COD. Additionally, of the ten records reviewed, four member records reflected group participation, three members attended four groups in a month and one member attended two groups. An additional member, not identified as	• The ACT team should continue their efforts to engage dually diagnosed members to participate in substance use treatment groups, as appropriate. Ideally, 50% or more of applicable members participate in a co-occurring group. • Staff may benefit from training on strategies to engage members in group substance use treatment. • Continue offering weekend and community substance use groups.

			having a COD, was engaged in weekly substance use treatment groups.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 - 5 4	Based on records reviewed and staff interviews, the team appears to use a Dual Disorders (DD) model. In general, most staff interviewed demonstrated understanding of the stages of change, and use of a stage wise treatment approach. The SASs see the primary goal as harm reduction rather than focusing on abstinence. Staff interviewed did not identify abstinence as a goal, rather supporting reduction of use as the team approach, stating abstinence can be "scary" for members and harm reduction is a more comfortable approach in supporting members. SASs reported providing ongoing training and education related to substance use to the ACT team on Wednesdays, and answers staff questions daily during the program meeting pertaining to members' stage of change. During the program meeting observed, staff identified members assessed stage of change, interventions, and recommendations were discussed amongst the team. Of the reviewed records, six members had a COD, but not all records had a treatment plan that reflected how the team would address and support the members in steps toward recovery.	• Ensure member treatment plans identify member goals and individualized needs including how the team will address and support the members' steps toward recovery. Seek compromise with members to address substance use planning on their service plans. Ensure members have current service plans that reflect their status and goals. • Continue current practices reported of educating the team weekly on best practices in treating individuals with a COD. • Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Dual Disorders Treatment, in the principles of a stage-wise approach to interventions, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new or less experienced staff. Identifying a co-occurring disorder model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in their recovery.
S10	Role of Consumers on Treatment Team	1 – 5 5	Although, the Peer Support Specialist position is vacant, the team has ACT staff with lived experience of psychiatric recovery. Review of data shows that the team continues to run peer groups with members. Members interviewed reported knowing of staff on the team that has lived experience of psychiatric recovery. Both members	

			and ACT staff report that stories of lived experience are shared by staff when appropriate.	
Total Score:		**105**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
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	5
10. Vocational Specialist on Team	1-5	2
11. Program Size	1-5	4
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	4
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	4
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.75**	
Highest Possible Score	**5**	