ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: September 19, 2014

To: Lindsy Morrison, Site Administrator

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ADHS Fidelity Reviewers

Method

On September 3 - 4, 2014, Georgia Harris and Karen Voyer-Caravona (Fidelity Reviewers) completed a review of the CHOICES South Central Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

CHOICES South Central is located at 1616 East Roeser Road in South Phoenix. The ACT team serves 88 Behavioral Health Recipients (members), 48 of whom are diagnosed with a co-occurring disorder. The team is comprised of 10 permanent staff: the Team Leader/Care Coordinator, two Substance Abuse Specialists (SAS), a Peer Support Specialist (PSS), a Rehabilitations Specialist (RS), an Employment Specialist (ES), a Transportation Specialist (TS), an Independent Living Specialist (ILS), a Housing Specialist (HS), and a Case Manager (CM). In addition, the team includes a full-time temporary Psychiatrist and a full-time temporary nurse. The clinic site has adequate parking and is near a bus route. The ACT team has been operating at the South Central clinic for approximately 12 months since the team relocated from the CHOICES Arcadia location. Approximately eight ACT members from the original Arcadia ACT team transferred to the supportive Arcadia team in order to remain at that location, which, unlike the South Central clinic, is located in a more economically-advantaged area of Phoenix with more accessibility to services, public transportation and attractive housing and job options.

During the site visit, reviewers participated in the following activities:

- Observation of a daily ACT team meeting,
- Interview with the ACT Team Leader,
- Interviews with Substance Abuse Specialist, Employment Specialist, Housing Specialist, and
- Group interview with nine members being served by the ACT team.

- Charts were reviewed for 10 members using the agency's electronic medical records system, with assistance from the Team Leader.

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 Choices South Central ACT team works as a cohesive unit. The doctor, a *locum tenen,* provides direction, leadership, education and support to all team members. The team actively engages members who are hospitalized and works diligently to ensure a successful discharge. The ACT team has been operating at the South Central clinic for approximately 12 months since the team was moved from the CHOICES Arcadia location. In addition to the clinic's location change, the team has undergone significant staff turnover but has managed to minimize interruptions in service to its members.

The agency demonstrated strengths in the following program areas:

- Small caseloads: the ACT team staff to member ratio is below 10:1.
- The team effectively demonstrates the ACT principle of *Team Approach* by sharing roles and responsibilities for each member.
- Both of the Substance Abuse Specialists came to the team with previous experience in substance abuse and case management, and they also self-identify as peers with shared experiences of substance abuse and recovery.
- The ACT team provides 68.5% of services in the community and averages 4.5 contacts with each member per week.
- The ACT team is actively involved in hospital admissions and discharges. Staff and the Team Leader are proactively involved in decisions to hospitalize, accompanying members to the hospital, visiting them during their stay and engaging family members for support and aftercare. They also collaborate with hospital social workers and case managers for discharge. The ACT team regularly uses street outreach approaches and legal mechanisms to keep members engaged in treatment, including Mental Health, Veterans Mental Health and Criminal Courts to provide support and advocate for their needs.

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

Team Services and Contacts

- If primary caseloads are assigned for specific paperwork-related tasks, ensure the specialty staff are able to perform their specialist role as a primary function on the team. Preferably, staff would not have individual caseloads, but the team as a unit would be responsible for service provision to support members.

Practicing ACT Team Leader

- While the ACT Team Leader is committed to supporting the staff and providing members with a choice in treatment, the majority of the leader's responsibilities appear to be administrative. It is recommended that the ACT Team Leader spend at least 50% of the time providing direct services.
- If all identified administrative functions are required of the Team Leader, consider looking for other agency supports that could assist with some of these. Otherwise, this role and relative responsibilities may be an area of further review at the system level.

Substance Abuse Treatment

- Nearly 54% of members were identified with having a co-occurring disorder. At the Provider Network Organization (PNO) and Regional Behavioral Health Authority (RBHA) level, explore training and educational options that could result in licensing and certification necessary to allow staff to provide individual counseling and substance abuse treatment.
- At the PNO and RBHA level, consider structural changes that integrate outside provider of individual counseling services as full-fledged members of the team.
- Ensure that staff or outside providers of co-occurring disorder treatment groups provide a written summary of progress and level of participation on at least a monthly basis for the member records.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	With 11 ACT staff and a roster of 88 members, the ACT team staff to client ratio is below 10:1. This count excludes a full-time and temporary Psychiatrist.	• The agency and the ACT Team Leader should continue to monitor and manage the team's caseload ratio below 10:1.
H2	Team Approach	1 – 5 5	ACT members are being served by multiple staff members, in-person, more than 90% of the time. ACT staff members are assigned zone, which rotate monthly, for community visits, so that all staff members get to know all members and their needs. Although ACT team members each carry their own caseloads, staff share the roles and responsibilities. For example, during the team meeting, a more senior member of the team shared his knowledge to a newer staff member about particular BHR behavioral pattern when decompensating. At the same meeting, staff repeatedly volunteered to step in for other staff members when conflicting duties interfered with delivering client services. Staff members also shared knowledge pertaining to their area of specialization in order to help one another attend to client concerns and goals, including offering substance abuse assessments or giving guidance on a vocational services issue.	• If primary caseloads are assigned for specific paperwork related tasks, ensure the specialty staff are able to perform their specialist role as a primary function on the team. Preferably, staff would not have individual caseloads, but the team as a unit would be responsible for service provision to support members. • Continue efforts to provide services to members with primary consideration for need and staff specialty versus general caseload assignment in order to ensure a variety of team members are involved in each member's care. • Continue team approach to individuals who are hospitalized to ensure contact occurs at least weekly per month, with multiple staff involved in face-to-face contact and coordination of activities.
H3	Program Meeting	1 – 5 5	Staff team members participate in a morning meeting five days a week (10 a.m. – 11:30 a.m.) and discuss each ACT member. Staff is expected to attend all team meetings and participate in discussion of member status, needs and proposed interventions. The Team Leader assumes an active supervisory role in the meeting, asking questions, directing action on member behalf and stating	

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			intentions to accompany Case Managers to hospital discharge planning meetings to support member aftercare needs. The Psychiatrist attends four meetings a week, and the nurse also attends. The team used a tracking form listing all members and their current status, including current medication and housing location. Staff reported on recent contacts with members, interactions with social supports, and collateral contacts with housing and hospital social workers. During observation of the ACT daily meeting, reviewers observed cross disciplinary coordination, as well efforts to rearrange schedules to ensure member supports were available at court or discharge planning meetings.	
H4	Practicing ACT Leader	1 – 5 2	The activity log indicates the Team Leader does not provide as frequent direct face-to-face member service as he thought. In the four week period prior to the review, the Team Leader spent 8.4% of his time dedicated to direct member services.	• Review Team Leader administrative activities to determine if all are essential and required through the involved stakeholders or other oversight entities. • If all leader administrative activities are deemed essential, consider if there are other supports the clinic that could assist in completing some or all of those tasks which may allow the Team Leader to provide increased direct service to members. • If all identified administrative functions are required, Team Leader responsibilities may be an area of further review to determine if action should occur at a system level. The need for this level of intervention cannot be fully confirmed at this time.
H5	Continuity of Staffing	1 – 5 3	Data provided by the Team Leader showed that over the course of the last 24 months, 11 staff left 12 positions, reflecting a staff turnover of 45% for	• Consider exploring the reasons employees cite for making a change in position that leads to staff turnover. This may be an

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			that period. For the period between January – March 2014 the agency was fully staffed. The lowest period of staffing fell between May – July 2014. The Team Leader reported that the positions of SAS and PSS appeared to be the most difficult positions to fill.	area of further ongoing network, clinic and system review. • Consider implementing experiential hiring practices such as job shadowing for potential new ACT team staff, particularly for those job candidates new to the ACT model.
H6	Staff Capacity	1 – 5 4	Though the ACT Team has seen a complete staff turnover in 24 months, the team maintained an overall capacity level of 85.4% for the last 12 months. The Psychiatrist and nurse positions have been vacant since April 2014. At the time of the review a Locum Tenen (LT) and a temporary nurse were filling those roles on a full-time basis and all staff interviewed reported high satisfaction to their contributions to the ACT team.	• Consider exploring the reasons employees cite for making a change in position that leads to staff turnover. This may be an area of further ongoing network, clinic and system review.
H7	Psychiatrist on Team	1 – 5 5	The full-time Psychiatrist is an LT who works four, 10-hour days. He plays an active role on the ACT Team. ACT team staff report that he provides psychoeducation on diagnostic indicators and drug interactions and shares his concerns for member needs based on his other areas of medical experience, including neurology and veterans care. The Psychiatrist goes out into the field with staff on a rotating basis. The team additionally describes the LT as flexible and responsive to members' needs. The LT makes recommendations for hospitalization based on clearly-defined criteria. Staff report that the Psychiatrist's time is 100% dedicated to ACT, although he does provide occasional emergency coverage to the South Central clinic when the other Psychiatrist is out.	• It is recommended that the clinic and PNO explore options for obtaining hiring a full-time permanent Psychiatrist for the ACT team. It may be helpful to identify factors contributing to the position remaining unfilled for four consecutive months at the time of the review.
H8	Nurse on Team	1 – 5	Though the ACT team nurse is a temporary staff member, she is full time and has extensive	• It is recommended that the clinic and PNO explore options for obtaining two full-time

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		3	experience as a psychiatric/ACT team nurse. The ACT team staff value her flexibility, accessibility, willingness to go out into the community, and ability to provide useful input on members in team meetings. Some staff reported that they hoped she would stay on the team permanently. Currently, the nurse's schedule is quite full. Staff members acknowledged that other teams try to encroach upon her time whenever possible.	permanent nurses dedicated to the ACT team. Two nurses will ensure flexibility and availability of medical services such as injections and labs in the community and at the clinic. It may be helpful to identify factors contributing to the position remaining unfilled for four consecutive months at the time of the review.
H9	Substance Abuse Specialist on Team	1 – 5 5	The team includes two Substance Abuse Specialists with previous case management experience and additional experience in adolescent treatment, inpatient psychiatric care and as an Emergency Medical Technician (EMT). Both SAS staff are self-identified as peers in recovery for substance abuse. The SAS interviewed by the Fidelity Reviewers could articulate understanding and commitment to basic principles of harm reduction, stages of change and Integrated Treatment of Co-Occurring Disorders. The SAS interviewed reports using motivational interviewing techniques to facilitate change thinking and behaviors. The SAS recognizes abstinence as an ideal, but also cited a member switching from methamphetamines to marijuana as an example of "harm reduction".	• Review training and supervision options to ensure staff designated with a substance abuse specialty receive monitoring, support and education in their role, for the population served. Assure that the designated Substance Abuse Specialists are providing co-occurring disorders specific individual and group counseling sessions (See items S7 & S8).
H10	Vocational Specialist on Team	1 – 5 5	The ACT Team included an Employment Specialist and a Rehabilitation Specialist. Previous to joining the ACT team, the ES worked for five years as a counselor with Vocational Rehabilitation (RSA/VR). The ES views all members as having the right to explore competitive employment even if engaging in substance abuse, stating that time spent at work is less time spent abusing drugs and alcohol and that success at work could motivate later	• The fact that ACT vocational staff carry their own caseload appears to be limiting time to perform adequately in their areas of specialization in-depth, resulting in the brokering out of employment services. Consider ways to relieve this requirement so that the VS can carry out a full range of employment services.

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			commitment to treatment and sobriety. The RS has past experience with Job Corp. Staff report referring members to supportive employment providers for job development and placement services when necessary.	
H11	Program Size	1 – 5 5	The ACT team consists of 12 full-time staff.	
O1	Explicit Admission Criteria	1 – 5 4	Admission to ACT is based on written criteria set by the RBHA. Screening is done by the Team Leader, who meets with the person individually, discusses them with the team, with the final decision to accept made by the Psychiatrist. Potential members must be willing to accept the ACT level of intervention. Despite explicit admission criteria, the team faces and bows to administrative pressure to accept clients they do not feel are appropriate usually behavioral health recipients whose primary diagnosis is a Diagnostic Statistical Manuel (DSM)IV-TR Axis II personality disorder. The team is often able to facilitate transfer to a more appropriate level of care for these individuals.	• Review each ACT referral and maintain the established admission process to ensure the appropriateness of each member to the team.
O2	Intake Rate	1 – 5 4	The team accepted 20 admissions to the ACT team in the last six months. The team accepted two admissions in August and tries to accept no more than six. However, staff report that there were three hospital discharges in one month (spring 2014) in which eight were admitted.	• It is recommended that the team continue to adhere to the ACT admission criteria. Also, in the event that admissions should rise above six in one month, the team should develop proactive solutions to ensure that the staff to member ratio stays within acceptable range.
O3	Full Responsibility for Treatment	1 – 5	In addition to case management services, the ACT team provides housing services (including ACT	• Consider options that will broaden the scope of services in the ACT program areas

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	Services	4	housing), partial employment/rehabilitative services, two substance abuse treatment groups, and psychiatric services and medication management. The team does not have licensed staff to provide individual counseling/psychotherapy or individualized counseling for substance abuse. Members in need of those services may be referred to outside providers such as Lifewell, which is co-located at the clinic, or Phoenix Interfaith. ACT also refers members to day treatment programs, Friendship and Momentum, both licensed to provide substance abuse treatment. While about 11 members reside in ACT housing, those units are owned by Lifewell and not managed by the ACT team. Residents can be evicted for drug use and must participate in groups or some meaningful community activity to keep their housing. However, ACT staff views ACT housing as a temporary situation, and they assist members in applying for Section 8 housing to prepare them for further community integration. Eight members reside in supervised care homes, where they receive partial case management services such as medication observations and meal preparation. The Team Leader is working closely with the ACT HS to train her in supporting members in maintaining their housing needs regardless of where they live. Because of the administrative responsibilities associated with carrying a specific caseload, employment services cannot be implemented to the extent intended by the ACT model. The ES has	such as individualized counseling and substance abuse treatment. • Consider options that will minimize the need for the team to refer to outside agencies for services that are to be provided by the ACT team (e.g., vocational services). • At the network and clinic level, continue to review training and supervision options to ensure that staff designated with a specialty receive monitoring, support and education in their role. • At the network and RBHA level, explore training and educational opportunities for staff that lead to certification or licensure to facilitate the provision of individualized counseling and substance abuse treatment.

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			only had one opportunity to be directly involved in job coaching a member. Instead, supported employment (SE) services are referred to outside brokers (e.g., FOCUS, WEDCO or VR).	
O4	Responsibility for Crisis Services	1 – 5 5	The team assumes responsibility for crisis services, with crisis services coverage provided 24 hours-a-day, and seven days a week. The ACT Team Leader reported the staff members rotate being the primary on-call staff. The backup on-call staff is always the ACT Team Leader.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Although staff interviews reflected an estimated ACT team involvement in psychiatric inpatient admissions at 80 – 85%, further review indicated that the team was involved in 100% of the last 10 admissions. In the case of voluntary hospitalizations, the team's protocol requires a face-to-face meeting between the member and the team Psychiatrist for assessment and a recommendation as to whether or not to hospitalize. If the Psychiatrist recommends inpatient hospitalization, the team will work with the member as to choice of hospitals and accompany him or her to the intake in order to help provide necessary information, including psychiatric history, current medication, housing and support system. If the member is not willing to voluntarily accept hospitalization, the team will use legal mechanisms (i.e. court ordered treatment) to ensure the necessary care. However, at times the ACT participants self-admit and the ACT team will not learn about the hospital admission until after the fact.	• It is recommended that the ACT team continue efforts to collaborate with hospitals, clinics, and area human service programs that could share information about potential crisis leading to a hospital admission. • Continue efforts to engage members' social support networks including family, landlords and faith-based support in order to further enhance proactive engagement when members are experience crisis or an increase in psychiatric symptoms. • At the clinic, PNO and RBHA level, consider investigating possible explanations for recent increase in inpatient admissions and make plans to proactively address patterns (e.g, seasonal, changes in policy at state and federal level affecting delivery of provision of service) within the larger system.
O6	Responsibility for Hospital Discharge	1 – 5	The staff were involved in 100% of the last ten hospital discharges. The CC takes an active role in	• At the PNO and RBHA level, consider strategies for ensuring hospitals and detox

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	Planning	5	the discharge planning process, attending planning meetings with case managers to educate staff and support members. The ACT team protocol is to be physically present with the members at the time of discharge. However, when members are hospitalized without the knowledge of the ACT team, some hospitals, due to concerns about possible HIPPA violations, will neither confirm nor deny member admission to ACT team. Staff reported that a small number of hospitals discharge members without seeking input or assistance with aftercare from the ACT team. This has resulted in members being discharged before they are ready, with subsequent readmission within 24 hours. The team tries to utilize the hospital services of those that make efforts to collaborate with the ACT team on discharge planning.	programs make every effort to obtain release of information and that ACT teams are identified, so that members are not released on to the street without a plan for medication management, safe and sanitary housing or other shelter, and social supports to reduce the need for hospital readmission.
O7	Time-unlimited Services	1 – 5 4	In the past 12 months, the ACT team has a 14.7% rate of discharges. When members request step downs, the team holds a staffing with the recipient and his or her support system. The next step is to go to the clinical director and provide a Notice of Action. To honor the member's successes in ACT, he or she is given at least two certificates highlighting process and participation. The ACT team prefers not to use the term "graduation" because it connotes finality or may convey a perception that they are being kicked out. The team will facilitate the transition to the receiving supportive team to provide summaries of the person being stepped down. Cases are not closed out for 30 days in case the member decides to return to ACT. Additionally, members are told they can return to ACT if they feel they need more	• It is recommended that the ACT team establish a written statement of clear examples of progress milestones that support graduation and that those are • Explicitly documented in member records. • It is recommended that the ACT team review SAMSHA protocols for a thorough understanding of time-unlimited services to gain a broadened understanding of recovery. • It is recommended on the RBHA level that the system monitor and use training and education to reinforce the definition of recovery in evidence-based practice.

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			intensive services again. While the Team Leader embraces the model and makes efforts to train and educate staff in the ACT model, staff interviews suggest that the team may perceive it as a "temporary service" from which "they can find recovery".	
S1	Community-based Services	1 – 5 4	The ACT Team Leader prioritizes community-based services and describes this delivery goal as a key to building the ACT team during this first year in the position. Staff and member interviews and the observation of the team meeting suggest that the team has also internalized the importance of meeting with members in their natural setting rather than in the clinic. Staff referred to seeing recipients in their homes, at peer run programs, taking them shopping, and accompanying them to medical and legal appointments. Members interviewed discussed wanting more outings in the community such as movies and the park. The record review shows that community-based contacts occur at a median rate of 68.5%, with a range from 11.76% to a high of 97.78%.	• Continue efforts to engage members in natural community settings, particularly for those members who reside in ACT housing, supervised care homes or half-way houses, which do not reflect community integration.
S2	No Drop-out Policy	1 – 5 4	This team retained between 80-94% of their case load over the most recent 12-month period. Per interviews, 30 of those members were discharged. Of those 30 members, staff determined that 5.01% could not be served. One left the geographic area without a referral. Two threatened staff; one carried an Axis II, which is an inappropriate primary diagnosis for ACT team membership; one was determined to be seeking benzodiazepines and not appropriate for services, and one refused all efforts at engagement.	• If the team determines that a member would benefit from a service that the team believes it cannot adequately provide, ensure documentation outlines the specific support the receiving provider will offer that the ACT team cannot provide. • Continue with emphasis on assertive engagement mechanisms that reach membership in their community.

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				• Continue to utilize effective engagement with legal system via collaboration with probation officers, surveillance officers and court ordered treatment in order to keep members active in the program.
S3	Assertive Engagement Mechanisms	1 – 5 5	Member engagement strategies include medication observations, ACT home inspections, advocacy and support in mental health and criminal court, hospital visitations, and taking members to substance abuse treatment groups in the community. ACT staff also use legal mechanisms to keep members active in the program (i.e. court ordered treatment, parole officer, surveillance officer, representative payee, etc).	
S4	Intensity of Services	1 – 5 3	Members interviewed described feeling that visitations to ACT housing were often too brief and "superficial" ACT staff also use legal mechanisms to keep members active in the program (i.e. court ordered treatment, parole officer, surveillance officer, representative payee, etc). Some members shared that staff "sometimes are not proactive on what they could do to help . . . nip things in the bud early instead of waiting to take drastic measures . . . I wish they were more on top of drugs . . . people lose their housing if they have drugs or their house isn't clean . . . if something happens at the ACT house, they don't investigate it." A review of 10 member records indicate that for the four weeks prior to the review, the mean rate of face-to face time spent per member per week was 79.25 minutes, with a range of 61 to 131.25	• Review documentation expectations to ensure all face-to-face contacts are properly recorded. • Review potential barriers that prevent staff from higher face-to-face service time spent with members. • Consider what measures staff can take (e.g., reduction of referrals to outside providers, increase services through the ACT team) that could result in higher service intensity per member. • Team Leader should periodically review member records and staff schedules to ensure appropriate face-to-face contacts are being made. • It is recommended that the Team Leader and clinic explore options for freeing up time to supervise and mentor staff in developing strategies and meaningful

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			minutes. While time spent in direct, face-to-face contact falls within the mid-range of the rating scale, it should be noted that almost 70% of that time occurs in the community. The Team Leader encourages active engagement in the community and was seen giving direction for face-to-face contact. Staff report that the Peer Specialist is strong in assertive engagement and spends 90% of her time in field in direct member engagement. Nonetheless, final scoring was based on the minutes of service documented in the member record.	activities to increase face-to-face time with members in the community.
S5	Frequency of Contact	1 – 5 5	A review of 10 member records provides evidence of a mean rate of member contact with staff per week of 4.5., with a range of 3 to 13.25 contacts per week.	
S6	Work with Support System	1 – 5 2	During the daily meeting observation, staff reported collateral contacts with individuals in the members' support network, including landlords, pastors, and family members. Contacts with informal supports were also found in several of the member records, primarily when or shortly after members had been hospitalized. The ACT team reports that approximately 55% of members have no identified support system outside of ACT. Of the 45% who have an identified support network, the team makes efforts to obtain a release of information (ROI). Per the Team Leader interview, staff make contact with one to three supports of members with an identified support network per month. Staff describe social supports as highly valued for their role in members achieving recovery goals: "I don't want to be their main support system." "They (informal supports) are our second line of defense". "However . . . many	• Continue to ensure that ACT staff review the potential benefits of engagement with an informal supports, and attempt to secure an ROI allowing staff to contact potential supports. • If a member has an identified support system, but declines to sign an ROI allowing the team to initiate contact, this should be documented in the member record. • Ensure that staff understand that if a support contacts the team, it would generally be appropriate for ACT staff to receive information from the support.

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			have damaged relationships." One member shared that he had lost his adult children because "you can't have a family and party." Team members nonetheless ask about social supports and attempt to get an ROI every time they complete a Part E (annual or change in status assessment), Meaningful Activities Worksheet (MCAW) or At Risk Crisis Plan (ARCP) with members. Per the record review, the ACT team had a rate of one contact a month with a social support across the entire caseload.	
S7	Individualized Substance Abuse Treatment	1 – 5 2	Although the ACT team includes two SAS staff with at least one year of training and/or professional experience in substance abuse treatment, neither are licensed to provide substance abuse counseling or therapy. Individual substance abuse counseling and psychotherapy, when prescribed, are referred to outside providers, including Lifewell, which is co-located at the South Central clinic. It was reported that Lifewell staff attend the Monday daily meeting weekly to discuss member issues.	• At the PNO and RBHA level, explore training and educational options that could result in licensing and certification for individual counseling and substance abuse treatment. • Also at the PNO and RBHA level, consider structural changes that integrate outside providers of individual counseling services as full-fledged members of the team.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The ACT team's two SAS staff provide a Monday substance abuse group and transport members to a substance abuse group in the community on Fridays. The group began meeting three weeks prior to the date of the review and utilizes the activities and ideas compiled in a workbook *ACT Team Substance Abuse Group Curriculum* created by the RBHA. The workbook does not represent a formally- structured, meeting-by-meeting	• Review the substance use treatment groups curriculum to ensure a structured, evidence-based, co-occurring disorders treatment model is utilized. Several good manuals contain curriculum and strategies to engage clients in stage-wise treatment groups. • Ensure staff designated to provide co-

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			curriculum, but allows the facilitator discretion to choose between five domains: education, building coping skills, identification of stages of change, supporting recovery and activities for interactive learning. The domains emphasize a strengths focus, celebrating any and all successes, the expression of feeling, tolerance of disruptive behavior and inclusion without a sobriety requirement. Sessions are supportive in nature rather than treatment oriented. Per interview, SAS and other ACT staff received training in how to use the workbook from the RBHA.	occurring treatment focused groups coordinate the content of the groups, track attendance at each group, and lead coordination of services related to substance use treatment on the team. • Ensure that staff or outside providers of co-occurring disorder treatment groups provide a written summary of progress and level of participation on at least a monthly basis for the member record.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Interviews with the Team Leader and staff, including one SAS, suggest that the ACT team is familiar with and starting to occasionally utilize the Co-Occurring Disorders model. Interviewed ACT team members used stages of change language and discussed how they use motivational interviewing techniques to facilitate movement from pre-contemplation to contemplation stages. The SAS interviewed said his shared experience aided him in recognizing when members are moving from pre-contemplative to contemplation in the stages of change. While staff view abstinence as a desirable goal, they consider it an ideal; harm reduction strategies can support improved independent functioning in the community. The ES reported that he does not believe substance abuse should be a barrier to competitive employment and that work could serve as motivation to begin contemplating a reduction in use or substance abuse treatment. Staff also utilize traditional 12-step strategies and transport members to a weekly community based Narcotics Anonymous group.	• At the team, PNO and RBHA level, continue efforts to provide education and training on Integrated Treatment for Co-Occurring Disorder as a stage-wise treatment approach. Standardizing basic tenant of treatment may help ensure consistent interventions across the system.

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S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team includes a PSS, who has full status as a team member, carrying a case load and an equal share of responsibilities. The Team Leader and other interviewed staff spoke highly of her ability to engage members and meet with them in the community. Along with the PSS, both SAS staff are self-identified peers in recovery for substance abuse and use their shared experiences to not only engage members in treatment but also to inform their judgments about an ACT recipient's stage in the change process and subsequent interventions.	• Continue to recognize and prioritize peer contributions and shared experience in treatment services.
Total Score:				

ACT FIDELITY SCALE SCORE SHEET

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

5. Responsibility for Hospital Admissions	4
6. Responsibility for Hospital Discharge Planning	5
7. Time-unlimited Services	4
Nature of Services	
1. Community-Based Services	4
2. No Drop-out Policy	4
3. Assertive Engagement Mechanisms	5
4. Intensity of Service	3
5. Frequency of Contact	5
6. Work with Support System	2
7. Individualized Substance Abuse Treatment	2
8. Co-occurring Disorders Treatment Groups	2
9. Co-occurring Disorders (Dual Disorders) Model	3
10. Role of Consumers on Treatment Team	5
Total Score	**112/28=4**