ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: July 8, 2021

To: Peggy Chase, President & CEO

From: Karen Voyer-Caravona, MA, MSW
Annette Robertson, LMSW
AHCCCS Fidelity Reviewers

Method

On June 1 -2, 2021, Karen Voyer-Caravona and Annette Robertson completed a review of the Terros Health 23rd Avenue Health Center Assertive Community Treatment 2 (ACT 2) 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 2 team is operated by Terros Health, a comprehensive healthcare organization, integrating behavioral health and primary medical care. The agency has four ACT teams. Two ACT teams, ACT 1 and ACT 2, are located at the 23rd Avenue Health Center in Phoenix, Arizona.

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.

It was reported to the reviewers that the public health emergency did not significantly alter the manner in which ACT services were delivered. Staff said that agency leadership offered staff options for continuing operations in a safe manner. Member input on how to meet was also sought and accommodated. Staff reported continuing to meet with members in-person but did so at a safer distance, outside members' homes for the safety of the members and staff, following public health guidance. Staff described their initial impressions of using virtual platforms to conduct the team meetings as distracting and unhelpful with the flow of the meeting; remote technologies appear largely abandoned in favor of social distancing and other public health guidance for in-person contacts. Staff interviewed endorsed making safe accommodations to deliver in-person services, including conducting individual and group substance use treatment in outdoor locations. At the time of the review, the staff interviewed appeared to be welcoming the removal of restrictions imposed by the public health emergency but understanding of the reluctance of some members to re-engage in-person.

The individuals served through the agency are referred to as members, and for consistency across fidelity reports, the term "member" will be used.

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

- Remote observation of a program ACT team meeting on June 1, 2021;
- Individual interview with the Team Leader/Clinical Coordinator (CC);
- Individual interviews with the Substance Abuse Specialist (SAS), the Employment Specialist (ES), and the Peer Support Specialist (PSS);
- Individual phone interviews with five members participating in ACT services;
- Review of electronic medical records of ten members receiving ACT services; and
- Review of documents such as member and co-occurring disorders rosters; copies of resumes and training records for the SAS, Licensed Associate Counselor (LAC), the ES, and the Rehabilitation Specialist (RS); the CC's encounter data; co-occurring disorders group sign-in sheets; calendars for the SAS and LAC; and ACT admission criteria and outreach guidelines.

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:

- Staff capacity: The ACT team operated at more than 95% capacity for the past 12 months.
- Psychiatrist and Nurses on team: The ACT team has a Psychiatrist and two Nurses who are fully dedicated to the care of the 100-member team.
- Responsibility for crisis services: The ACT team has full responsibility for 24-hours a day/seven days a week crisis services. Several members interviewed were able to describe crisis services and how to access them through information provided to them by the team.
- Time unlimited services: The ACT team offers time unlimited services with no expectation of graduation before members demonstrate and express comfort and readiness. The ACT team neither graduated members in the last 12 months nor anticipates graduating any in the next.

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

- Practicing Team Leader: Increase the CC's in-person provision of direct member care to 50% of their time. Identify opportunities to assist members in managing concerns about public health guidance and making choices regarding adaptions that lower risk to health and community spread. The CC's in-person services may include mentoring specialists in the field and accompanying the Psychiatrist or Nurse on home visits.
- Frequency and intensity of services in community-based settings: To the extent advised in public health guidance, identify, and resolve barriers to the intensity and frequency of in-person contacts made by ACT team staff in natural community settings where challenges, monitoring and skill building are the most likely to occur. With the model's emphasis on community integration, the team should avoid reliance on clinic-based groups.
- Assertive outreach mechanisms: Review outreach practices used with members who miss appointments (especially those scheduled with the Psychiatrist and the Nurses) or fall out of contact (especially post hospital discharge). Obtain from members advance direction on how to best locate them when they are out of contact. Discuss with member the value of including natural supports as partners in outreach. Ensure outreach efforts are consistently documented.
- Work with support systems: Increase and properly document all contacts with informal or natural supports, including texts, emails, and phone calls. Leverage the role of the Peer Support Specialist to help members and their supports find agreement on what support looks like in their recovery. Consider consultation and technical assistance in engaging and negotiating with natural supports to be valued participants in the member's recovery team.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	On the ACT 2 team, eleven staff, excluding the Psychiatrist, serve 100 members for a member/staff ratio of 9:1.	
H2	Team Approach	1 – 5 5	Per a review of ten randomly selected member records, 90% of members received contact with more than one member in a two-week period. The team uses a zoned coverage strategy in which four sectors of the service area are covered by a rotation of eight staff. Member contacts are tracked in daily team meetings and on a white board in the team room.	
H3	Program Meeting	1 – 5 5	The ACT team meets four days a week in person as a team to review all 100 members. The Psychiatrist attends the meetings on days they are scheduled to work. At the meeting observed, the CC lead the meeting and most staff actively participated, reporting on the status and needs of each member, their stage of change, and interventions to enhance motivation and reduce risk factors/harm.	
H4	Practicing ACT Leader	1 – 5 3	The CC reported spending between 18-20% of time in delivery of direct member services. The CC reporting accomplishing most direct member engagements before the morning meeting and at the end of the day. The CC prioritizes providing supervision to team specialists to maximize their effectiveness.	• Increase face-to-face member contacts to 50% of time. Practicing ACT leaders can engage in a range of member care needs including providing 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.
H5	Continuity of Staffing	1 – 5 4	The ACT team experienced 25% (n=6) turnover in the 24-month period before the review. All but one of those staff who left the team did so in the first half of that period.	• Examine staff motives for resignation and identify solutions to improve retention. Consider use of a *second chance* letter asking for consideration of returning to the position when valued staff leave the team. Optimally, ACT teams experience no more than 20% attrition during a 24-month period.
H6	Staff Capacity	1 – 5 5	The ACT team operated at 95% or more staffing for the 12-month period under review. The only position vacant was a nurse position for two months.	
H7	Psychiatrist on Team	1 – 5 5	The ACT Psychiatrist serves the team full-time, providing psychiatric care to 100 members four ten-hour days a week. The reviewers were told that the Psychiatrist has no outside responsibilities. Staff reported that the Psychiatrist was highly flexible to meet with clients, and accessible to specialists by phone and in person. Staff said that the Psychiatrist is active in team meetings as a leader and educator but also interested in staff input. Staff said that the Psychiatrist conducts home visits to see members who miss appointments or are not able to come to the clinic. Members interviewed reported that during the public health emergency they primarily met with the Psychiatrist over the phone.	

H8	Nurse on Team	1 – 5 5	Two full-time nurses serve on the team. It was reported that the Nurses attend team meetings on days that they are scheduled. The reviewers were told that the Nurses see members in the clinic and in the community, providing medication management, administering injections and delivering medications, coordinating care with primary care providers and medical specialists, and providing basic health and wellness education. Staff said that the Nurses are available after hours when necessary. It was reported that one nurse recently was promoted to nursing supervisor for the clinic but that this did not reduce availability to the team.	• Because ACT is designed for clients that are unsuccessful with traditional case management and require a higher level of service, ensure that supervisory responsibilities do not pull the Nurse Supervisor away from the ACT member care.
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has two staff responsible for providing co-occurring disorders treatment (COD) to the members dually diagnosed with a substance use disorder. The Licensed Associate Counselor (LAC) and SAS have both been in their roles with the team for more than one year. Recent online training completed by the SAS and LAC include *Motivational Interviewing*, *Use of Mindfulness in Recovery, SU Treatment and the Stage of Change Model, Biopsychosocial Model of Addiction*, and *Cognitive Behavioral Therapy in Substance Use Disorders Treatment*.	• It is recommended that the SAS and LAC receive specific and ongoing training in the co-occurring disorders or dual disorders treatment model.
H10	Vocational Specialist on Team	1 – 5 5	The ACT team has two vocational staff with at least one year of training and experience in vocational rehabilitation and support. The Rehabilitation Specialist has been employed in the role, serving members with a Serious Mental Illness diagnosis since 2007. Training transcripts show some agency provided employment training between 2014 and 2018. The Employment Specialist has been in the role for more than a year; the ES served as an RS on a supportive team	• It is recommended that both vocational staff receive ongoing training and education in supporting adults identified with an SMI/COD diagnosis find and retain competitive employment.

			between 2005 and 2017. Training transcripts show an ACT Employment Specialist training in 2020 and a supported employment training in 2014.	
H11	Program Size	1 – 5 5	The 100 member ACT team is served by 12 staff, including the Psychiatrist. All specialty roles are filled allowing for diversity and coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The team follows explicit admission criteria developed by the Regional Behavioral Health Authority. The CC screens referrals for appropriateness, including staffing with the referring CC. The CC then staffs the referral with the ACT Psychiatrist before offering services. The reviewers were told that most referrals to the ACT team are internal to the agency. Staff interviewed said that the CC and the Psychiatrist make the final determination of admission, but that referees can decline since the service is voluntary. Specialists interviewed were described the admission criteria as based on frequent use of inpatient and emergency psychiatric services and/or justice involvement, inability or difficulty with self-administering medication, needing support with independent living skills, chronic homelessness, and requiring higher intensity services. When asked by the reviewers if a diagnostic criterion was in place for admission, schizophrenia, bipolar disorder, and co-occurring disorders were identified.	
O2	Intake Rate	1 – 5 5	Data provided the reviewers showed 13 referrals to the team in the six months before the review, with no more than three referrals in any one month. The team has been adequately staffed for the period to accommodate needs of new members transitioning to the team.	

O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management and psychiatric services, the ACT team appears to have full responsibility for housing, counseling/psychotherapy, and substance use treatment services. Although it was reported that approximately ten members were working on employment goals, full credit could not be given because three were reported to be engaged in work adjustment training or sheltered programs via brokered providers. Provision of employment services in ACT emphasizes work in integrated/competitive settings. Some staff interviewed occasionally fell into "readiness" language and appeared to struggle with concerns about setting members up for failure due to persistence of symptoms or substance use. Although unrelated to the score for this item, it was noted that several records showed members attending clinic-based groups delivered by agency staff as opposed to ACT specialists. Other records showed some members engaged in court ordered individual treatment services delivered by outside providers.	• The ACT team, and vocational staff, in particular, may benefit from training or consultation on the concept of *zero exclusion* as well as the impact and benefits of work. Competitive employment is recognized as both a motivation for and a marker of recovery. An unsuccessful job outcome can be an opportunity to reflect on lessons learned and exploration of the consequences of personal choices rather than simply a failure or an indication of disability. Ideally, ACT teams are advocating for the member's stated readiness as opposed to steering to paid and unpaid work activities. This can discourage hope and momentum to active engagement in recovery services. • Increase efforts to keep members engaged in recovery-oriented services and supports delivered by the team in the community. Consider options to provide court ordered services and treatment through the ACT team. Ideally, specialty services such as substance use treatment and counseling/ psychotherapy are provided by highly skilled clinicians and/or under qualified clinical oversight to satisfy the expectations of stakeholders in the justice system. Specialists should be encouraged and supported in their professional development to achieve this outcome.
O4	Responsibility for Crisis Services	1 – 5 5	The Act team is fully responsible for 24-hour crisis services; the team is available to address crises 7am - 7pm Monday through Friday, and the on-call provides after hours and weekend response, including on-site. Crisis services rotate every two	

			weeks between three specialists. If the on-call cannot respond to a request, the backup on-call staff responds. The CC provides additional backup and consultation. Members are given fliers with staff and on-call numbers at intake and as needed. One staff reported giving members a card with on-call information. Some members reported that staff helped them program the on-call number into their mobile-phones. All members interviewed were knowledgeable about the on-call service; some reported having used it in the last year.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The team was responsible for 80% of inpatient admissions. Two members self-admitted to inpatient facilities. In one case, staff said that the member self-admits as a means of seeking shelter and safety when relapsing with substances, and staff also said that lack of a working phone is sometimes a barrier to members reaching out for assistance with admissions. In most admissions, ACT staff transported members to inpatient care. In one case, the team called law enforcement to assist in deescalating the crisis and transport the member safely to the facility. In another case, the team filed an amendment to a member's court ordered to treatment; law enforcement picked up the member and transported to the hospital. Staff said that since the public health emergency, most inpatient facilities admit members quickly because staff are not allowed inside beyond dropping off the member and providing documentation for admissions, the last psychiatric and nursing note, and the medication log. Staff said that coordination of care with inpatient teams is conducted primarily by phone. The team protocol requires that staff visit within 24 hours of	• The team should identify and seek solutions to barriers to direct team involvement in member inpatient admissions. Assess the quality of the therapeutic alliance; maintain stance of acceptance with member's readiness to accept recommended resources, services and supports, including housing and shelter. Focus on building trust and rapport with both members and their natural supports to increase team responsibility for hospital admissions to 100%.

			admission and every 72 hours afterward on a Monday, Wednesday, and Friday schedule. Since the public health emergency, contact is made by phone, although staff said that often members are sleeping so contact is not made. Staff said that special permission is needed at most facilities to see the member in person during hospitalization, usually due to court mandates.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per a review of data provided, the ACT team was involved in 100% of the last ten inpatient psychiatric hospital discharges. Staff interviewed said that the team is directly involved in nearly all inpatient discharges, from discharge planning that begins at admission to picking members up from the facility and taking them home or where they plan to stay. Staff said that aftercare includes assessing needs by first bringing them to the clinic to engage with the team, ensuring medications are filled, provision of groceries and necessities, and a five-day face-to-face contact protocol. In addition, staff schedule a follow up visit with the ACT Psychiatrist within 72 hours of discharge and with a Nurse the following week. The Nurse coordinates with the member's primary care provider (PCP) for a visit within 30 days. Some variations do occur. In one discharge, the team met the member at the hospital, engaged and collected paperwork though member had arranged other transport home; the five-day follow up was completed. In five cases, the team reported not all attempts to make contact during the five-day follow up were successful. The team contacted one member indirectly through a natural support. In two other cases, members were difficult to locate, despite outreach, and having been placed on outreach. Some members discharged had natural supports,	• Periodically discuss with members the benefits of giving the ACT team permission to contact natural supports, particularly on matters pertaining to crisis and inpatient psychiatric hospitalizations. Whenever possible, enlist natural supports in discharge planning to ensure successful monitoring and five-day follow up post discharge.

			whose involvement in aftercare plans was not specified.	
O7	Time-unlimited Services	1 – 5 5	A review of data provided showed that the ACT team did not graduate any members in the 12 months before the review. Staff interviewed did not anticipate graduating any members from the program in the next 12 months. Staff said that should a member be assessed as appropriate for a lower level of care a step-down process would be developed based on the member's comfort.	
S1	Community-based Services	1 – 5 3	Per member records sampled for a period before the public health emergency, 55% of member contacts occurred in community settings. The reviewers found few examples of ACT specialists engaging members in community settings where skills and new behaviors can be practiced, or resources acquired. One record showed that a member who desired homeless housing, presented as acutely psychotic and unable to attend to self-care, but received only three in-person contacts in a 30-day period. Although all contacts were in the community, there was no evidence (or documentation of) of how the team was assisting the member to address their situation or presentation. Several records showed community contacts for medication observation or hospital visits. Three records showed members engaged in clinic-based services such as activity and/or treatment groups (i.e., sewing, poetry, cooking, communication skills, depression, grief and loss), several of which were delivered by staff not assigned to the ACT team.	• ACT programs in good fidelity emphasize contacts in natural, community settings for optimal status monitoring and skill development. Skills demonstrated in clinic-based groups, designed primarily for socialization and to offer meaningful activities, may not transfer to community settings, where challenges are more likely to occur. Increase total services to at least 80% delivered in the community.
S2	No Drop-out Policy	1 – 5 5	The ACT team retained 96% of members per data provided for the 12 months before the review. The percentage calculated did not include those members who transferred to other ACT teams,	

			went into the custody of Department of Corrections, or died. Four members were closed out after the team was unable to locate them in eight weeks of outreach and were later discovered to have left the area without a referral. Staff reported that if a member is Non-Title 19, they will close the member. If the member remains Title 19, they will move them to Navigator status. Staff interviewed could not identify anything the team could have done differently to retain the members who were closed and that in most cases members who fall out of contact with the team will re-engage after a hospitalization. Staff said that three members sought a lower level of care and, although not in agreement, the team assisted in their requests to transfer to supportive teams.	
S3	Assertive Engagement Mechanisms	1 – 5 3	The reviewers were provided with a copy of the team's outreach protocol, which describes outreach activities conducted weekly over eight weeks. Following guidance provided by the Regional Behavioral Health Authority (RBHA), members are outreached four times each week for eight weeks. Staff described outreach activities such as home visits or going to preferred locations; phone calls; contact with natural supports; contact with hospitals, the morgue, and detention centers; contacting payees, shelter programs, and other service programs. Staff described occasions of using legal mechanisms to keep members engaged, especially for those who are justice involved. These may include contact with legal guardians and probation officers and filing petitions if the person is a danger to self or others. One staff acknowledged that in one such instance the member lost trust in the team after being	• Ensure timely follow up with members who miss appointments (especially those scheduled with the Psychiatrist and the Nurses) or fall out of contact (particularly post hospital discharge). Partner with members in advance as to how to best locate them when they are out of contact. Discuss with member the value of including natural supports as partners in outreach. • The team should develop a strategy to ensure complete and timely documentation of efforts to locate members who have missed appointments or are on formal outreach, possibly at the time that they are reported upon in the daily team meeting.

			petitioned and asked to be transferred to another ACT team. Although several records showed evidence of outreach and engagement activities, these strategies did not appear to be consistently documented or applied. Records reviewed showed numerous instances of no documented follow up or outreaches to members or natural supports after missed appointments. One record showed no documentation of five-day follow up after an inpatient discharge.	
S4	Intensity of Services	1 – 5 3	Per a review of sampled member records, median face-to-face service duration was 69.5 minutes for a week period. Range of duration was 6.26 minutes to 111.25 minutes. Median service duration did not include members engaged in services with staff not assigned to the ACT team.	• ACT prioritizes high service intensity delivered in natural settings where challenges are most likely to occur. Seek to provide an average of two hours or more weekly of face-to-face contact for each member. • Consider what activities members receive in group that could be provided individually to members by ACT specialists in community settings. Activities should be directly tied to goals identified by the member in their service plan and may include, cooking at the member's residence, meal planning and nutrition education at the grocery store, developing a budget over coffee or lunch, walking in a park to increase physical activity, or guiding the member in deep breathing exercise as a technique for emotional regulation.
S5	Frequency of Contact	1 – 5 3	The records review showed median frequency for face-to-face contact of 2.25 occurrences in a week period. The range of frequency was 0.5 contacts to 6.25.	• Increase frequency of service delivery by the ACT team to at least four or more face-to-face contacts per week for each member. Focus on community-based service delivery; engagements should

			Some staff interviewed often discussed member contacts in terms of billing or "fidelity" contacts rather than in terms of how they relate to service plans or as opportunities to address member needs and recovery goals.	address concerns meaningful to the member, promote therapeutic alliance with the team, nurture motivation to pursue recovery goals, facilitate access to resources, and support well-being/reduce harm. • See recommendation for Item S4*, Intensity of Services.*
S6	Work with Support System	1 – 5 1	A review of sampled records showed fewer than 0.5 documented contacts with members' natural supports in a month period. The reviewers counted 12 contacts with natural supports in the team meeting observed. Most members interviewed reported having a natural support and some reported knowledge that the team has at least occasional contact with them. One member reported that staff assisted with locating an estranged family member. In the team meeting observed, the reviewers heard two instances of the team engaging members and their family in counseling. Staff reported that approximately 25% of members have a natural support. It was noted earlier in this report that many members are engaged in clinic-based groups. Records showed many instances of staff inviting members to attend groups (other than co-occurring disorder treatment) at the clinic. Many of these groups replicate those provided outside the clinic by peer run programs, frequently referred to by staff using the misnomer "day programs", as well as those available in community settings.	• Assist members in developing a natural, community-based support system. Active participation with peer run programs are a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact. • Educate members and natural supports on the benefits of collaboration to support members' recovery goals. Some ACT teams describe the PSS as a significant contributor to this effort. • Encouraging clinic-based activities may limit members' opportunities to develop natural supports and social networks. As the community reopens and vaccination rates improve, consider opportunities for member engagement supporting identities and recovery visions outside that of behavioral health recipient. • Ensure consistent documentation of contacts with natural supports, which include contact by phone, email, and text. The ACT team should have four or more contacts per month for each member with a community support system.

S7	Individualized Substance Abuse Treatment	1 – 5 4	The SAS and the LAC provide individual substance use counseling to ACT team members identified with a co-occurring disorder. The reviewers were told that the SAS and LAC provide individual substance use counseling to approximately 21 members on the co-occurring disorders roster of 69. Members are scheduled weekly, although some do not consistently keep their appointment, and are seen for an average of about 35 minutes. The reviewers were told that although early in the public health emergency services were provided more often by phone, with reliance on public health guidance and member input, most treatment returned to in-person meetings in the member's home, other member preferred locations, and in the clinic. Staff reported using a stage-wise approach to co-occurring disorders treatment, meeting members at their stage of change, with the goal of getting them to the next stage of recovery through goal setting, identifying triggers, and exploring ambivalence to move to the next stage. Calendars provided the reviewers of a recent month before the review indicate that members with a co-occurring disorder receive less than 24 minutes of structured individualized substance use treatment weekly.	• Increase average member time per week in formal structured individual substance use treatment to 24 minutes or more.
S8	Co-occurring Disorder Treatment Groups	1 – 5 4	The ACT team provides members identified with the co-occurring disorders diagnosis two substance use treatment groups weekly. Early in the public health emergency co-occurring disorders treatment groups were held outside; in-person clinic-based groups resumed in December 2020. The SAS facilitates a group designed for	• Increase participation in co-occurring disorders treatment groups to 50% or more of members with a substance use disorder. • Ensure that co-occurring treatment groups reflect an evidence-based approach appropriately suited for the population served. On-line materials should be

			members at all stages of change. Staff reported that some treatment resources utilized are located on-line and not provided to reviewers. Staff reported that the groups use the stages of change model, with interventions such as motivational interviewing and the harm reduction approach. Topics include identifying triggers, coping skills, self-sabotage, and finding positive supports. The LAC facilitates a group for members in maintenance stage; the reviewers were told that those members are working on maintaining sobriety while also working on other life goals. Staff said that the maintenance group primarily covers relapse prevention. A review of member sign-in sheets from a 30-day period before the review showed that approximately 40% of members with a co-occurring disorder attended at least one group. Some members attending the maintenance stage group have met the criteria for remission and were removed from the co-occurring disorders roster. The all-stages group averaged 13 members per group, while the maintenance group averaged three. Staff said that most members with the co-occurring disorders diagnosis are in the pre-contemplation and contemplation stages of their recovery. Records reviewed from the period before the public health emergency showed that some members attended substance use treatment groups that were facilitated by clinic staff not assigned to the ACT team, or through the agency's intensive outpatient program. Some evidence of care coordination between the ACT SAS and the IOP clinician was located in records.	carefully reviewed to align with the dual disorders model. • Optimally, 50% or more of members with a substance use disorder attend at last one co-occurring disorder treatment group each month. All ACT staff should engage members with a co-occurring diagnosis to participate in treatment groups based on their stage of change with content reflecting stage-wise treatment approaches.

S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The ACT team appears to be primarily based in the dual disorders model. Staff interviewed appeared to be in the process of active learning and implementation of the dual disorders model. Staff were able to describe stages of change and relate them to stage-wise interventions. In the meeting observed by the reviewers, staff discussed the use of motivational interviewing and harm reduction strategies. Staff provided specific examples of recent approaches to harm reduction in working with members with co-occurring disorders. In one example, staff related discussing with a member switching the method of intaking an illicit substance to a less lethal means. Staff also reported supporting members who choose to use medically assisted treatment to address their addiction more safely. Although progress notes showed some evidence of occasional traditional language to describe sobriety (e.g., "clean and sober"), staff reported that they do not refer members to 12-step programs and rarely use detoxification programs unless requested by members who wish to use it for symptoms of physical withdrawal. Sampled records from a period before the public health emergency showed that some service plans did not directly address co-occurring disorders for those members with the diagnosis. Some staff interviewed had difficulty conceptualizing the dual disorders treatment framework without prompting from the reviewers. It was unclear if the team was using optimal resources for the evidence-based practice of co-occurring disorders treatment. For example, when asked for a copy of the curriculum from which the SAS and LAC derive content for groups, the reviewers were provided	• Ensure that all SASs and other specialists are provided training and education on the co-occurring model including the *stage-wise treatment approach (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention)*. Standardizing treatment around an evidence-based practice for co-occurring disorders treatment such as Integrated Dual Disorders Treatment (IDDT) supports consistent interventions implemented by staff across the team. • Technical assistance in integrated treatment for co-occurring disorders, including live training for all ACT staff may support consistent adoption of the co-occurring treatment approach.

			copy of the cover of *A Counselor's Treatment Manual - Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders.* The curriculum for stimulant use disorder may have relevant content but it is not evidence-based practice for co-occurring treatment for persons with an SMI.	
S10	Role of Consumers on Treatment Team	1 – 5 5	It was reported to the reviewers that a person with experience of psychiatric recovery provides members and educates the team on the peer perspective. The reviewers were told that this staff uses self-disclosure to members when appropriate and has the same level of responsibility as other staff. Members interviewed did not know if there was peer with lived experience of psychiatric recovery working on the team. Not all staff interviewed were aware of the nature of that staff's lived experience.	• Staff with lived experience of psychiatric recovery should be recognized as team assets for their insights into the peer perspective and potential for enhancing trust and rapport between members, and their supports, and all ACT specialists. All staff should be aware if there is a person with lived experience available as a resource for members. Members should be aware of who on the team has lived experience of psychiatric recovery.
Total Score:		4.29		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
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	5
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	5
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5

5. Responsibility for Hospital Admissions	1-5	4
6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	4
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	120/28=4.29	
Highest Possible Score	**5**	