ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 5, 2017

To: Laura Larson-Huffaker, CEO
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AHCCCS Fidelity Reviewers

Method

On April 4 – 5, 2017, TJ Eggsware and Karen Voyer-Caravona completed a review of the LaFrontera-EMPACT Madison 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.

LaFrontera-EMPACT provides behavioral health services to children, adults, and families. Outpatient and inpatient services are available and include: counseling, psychiatric services, substance abuse treatment, trauma healing, crisis intervention, supportive services, and services for adults with a serious mental illness (SMI). LaFrontera-EMPACT currently has three ACT teams: two in Phoenix, Comunidad and Capitol (located in the same clinic), and the Madison team in Tempe. The Madison team is the only team servicing SMI designated members at that clinic; the other teams provide adult general mental health services. At the time of the review, the Madison ACT team had been in operation for 12 months; therefore, the current review is its first. The ACT Manager reported that the ACT team was fully staffed with 11 clinicians: an ACT Psychiatrist, a Clinical Coordinator, a Nurse, two Substance Abuse Specialists, an Employment Specialist, a Rehabilitation Specialist, a Housing Specialist, an Independent Living Specialist, and an ACT Specialist. The team is also assigned a full-time Family Nurse Practitioner (FNP) who serves as the team's primary care provider (PCP). Approximately 2/3 of members currently have their primary medical care provided by the team's PCP.

The individuals served through the agency are referred to as "clients", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

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

- Observation of a daily ACT team meeting;
- Individual interview with the Team Leader/Clinical Coordinator (CC);
- Individual interviews with the Rehabilitation Specialist (RS) and the Employment Specialist (ES);

- Group interview with Substance Abuse Specialists (SAS);
- Group interview with six members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system;
- Review of agency materials: rosters of current and past ACT staff; a list of the last ten psychiatrist hospital admissions and discharges; list of members on Court Ordered Treatment (COT) status; the CC's encounter report; Clinical Contact Guidelines, including guidelines for outreach and engagement, hospital discharge follow up, and incarceration; RBHA ACT Admission Tool, and RBHA ACT Exit Criteria Screening Tool.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Small caseload: Excluding the ACT Psychiatrist and the ACT Primary Care Provider (PCP), the member/staff ratio is about 8:1.
- Team approach: Per a review of ten randomly selected member electronic records, 90% of members have contact with at least two ACT staff in two weeks.
- Substance Abuse Specialists on the team: The ACT team has two SASs who demonstrate professional knowledge and commitment to the substance abuse specialty. Both currently provide individual and group substance abuse treatment, with evidence of specific training in co-occurring disorders (COD) treatment, which positions the team to deliver high quality substance abuse services to members diagnosed with a COD.
- Vocational Specialists on the team: The ACT team's RS and ES each have previous experience providing vocational services to individuals diagnosed with an SMI and a COD. The team does not refer members to outside employment providers but conducts those services on the team. With specific training in assisting members in finding employment in integrated settings, including training in talking directly with potential employers and providing on-site follow along supports, the specialists are well-positioned to help the team achieve good outcomes in this area.

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

- Practicing Team Leader: Increase the CC time providing direct, face-to-face services to members to 50%. This service time can be spent providing training, shadowing, and mentoring to specialists. Prioritize contacts provided in the community where challenges are most likely to occur.
- Continuity of staffing: Strive to maintain the ACT team's current level of staffing so that turnover does not exceed 20% in two years. High turnover compromises the benefits of training and education in the evidence based practice of ACT and ACT appropriate

interventions. Maintaining continuity of staffing is crucial to building the trust and rapport with members diagnosed with a co-occurring disorder, have histories of repeated traumatic experiences, and are high utilizers of emergency psychiatric services.

- Intensity and frequency of services: Increase staff time spent with each member from an average of 76 minutes per week to two hours per week. Increase frequency of staff contacts with each member from an average of 1.88 contacts per week to four contacts per week. Continue to prioritize individualized services delivered in the community.
- Work with support system: ACT staff should increase contact with informal supports for each member who has them from .3 contacts per month to an average of four contacts per month. It is not required that contacts occur in the presence of the member.
- Co-occurring disorders groups: Increase the participation in co-occurring treatment groups from 33% of members diagnosed with a COD to 50%.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, 77 members were enrolled in the ACT team. Excluding the ACT Psychiatrist and the Primary Care Provider (PCP), the member to staff ratio was 8:1.	
H2	Team Approach	1 – 5 5	Per a review of ten randomly selected member records, 90% of members see more than one ACT staff in two weeks.	
H3	Program Meeting	1 – 5 5	The ACT team conducts a program meeting to discuss all members four days a week: Monday, Tuesday, Thursday, and Friday. All staff attend these meetings, except on their flex-day off. Wednesday is reserved for group supervision and staffings.	
H4	Practicing ACT Leader	1 – 5 3	The CC estimated that at the time of review 15% of his time is spent providing direct, face-to-face services to members. In ten member records, the CC documented six contacts over a month timeframe, which equated to about 12% of all service time. The CC said that much of his time is filled performing administrative duties. The CC is currently performing tasks normally reserved for the Program Assistant position, which was vacant at the time of review.	• The CC should spend 50% of his time providing direct care to members. Most of this time should be delivered in the community, and should include mentoring and shadowing specialists. • Investigate barriers to the CC providing 50% direct member service. Identify what, if any, administrative tasks could be performed by another clinic staff member. When filling the vacant PA position, consider any competencies required to effectively support the CC's administrative duties.
H5	Continuity of Staffing	1 – 5 2	At the time of the review, the ACT team had been in operation for 12 months. In that time the team has experienced considerable turnover, at a rate of 73%. Key positions of CC, the ACT Psychiatrist, Nurse, Housing Specialist (HS), Peer Support	• Identify and find solutions to any barriers to a turnover rate of no more than 20% in two years. • Incentivize staff retention through training and mentoring that supports professional

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			Specialist (PSS), and Independent Living Specialist (ILS) each turned over once. The position of ACT Specialist turned over twice.	developments in the areas of specialization. • When recruiting for staff positions, the agency should vet candidates as much as possible and ensure new hires have a full understanding of the demanding role of working on an ACT team.
H6	Staff Capacity	1 – 5 4	The sum total number of vacancies for each of the 12 months preceding the ACT team fidelity review was 27 for a capacity rate of 80%. The ACT team began operation in April 2016 with five staff. New staff were hired as the team filled its roster with new members, with approximately one staff added per month through August. When staff left positions, new staff were hired quickly, although it appears more time was taken to fill the vacant CC position.	• See recommendation for H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT Psychiatrist joined the team in January 2017. He was described by staff interviewed as "part of the team" but makes the final determination on member acceptance onto the ACT team and on psychiatric hospital admissions. The Psychiatrist is fully dedicated to the team, without outside responsibilities, and attends morning meetings three days a week, Tuesday, Thursday, and Friday. Staff interviewed described the Psychiatrist as having "an open ear" and accessible to them by phone, email and text. The Psychiatrist does not interrupt appointments with members unless in the event of an emergency. The Psychiatrist was reported to have been on home visits approximately three times since he joined the team.	• Consider options for the Psychiatrist to conduct weekly community based services to members, possibly accompanied by staff specialists.
H8	Nurse on Team	1 – 5 3	The ACT team has one Nurse serving the 77 member team. The nurse provides injections, puts together medi-sets, draws blood, and provides	• According to fidelity, a second full-time Nurse is recommended to support members' psychiatric needs. Ideally, two

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			medical education to members. Per staff report the Nurse goes out in the community an average of five hours a week for home visits. The Nurse attends four program meetings a week, and has no responsibilities outside the team. Staff reported that she makes herself very accessible to them via cell phone and text. According to the ACT Manager, the team does not have plans to add a second Nurse to the team. The ACT team also has a Family Nurse Practitioner (FNP), who serves in the role of the team's full-time PCP. Program Leadership reported that the PCP role supports the agency's commitment to integrating members' physical and behavioral health care; members are more able to readily access the PCP as a resource than by going to an outside provider. Approximately 2/3 of members see the ACT PCP, who has no responsibilities outside the team. Members can opt to see a private PCP. The PCP also attends the all of the program meetings, except the Wednesday supervision meeting. She occasionally conducts home visits and accompanies members to appointments with medical specialists. According to staff the PCP provides occasional back up to the duties of the Nurse, although reviewers did not see evidence of this in the record review.	nurses would coordinate their time to provide services to members within both the clinic and the community. • While the FNP position is a benefit for members to help coordinate medical care, this cannot replace the role of the ACT Nurse.
H9	Substance Abuse Specialist on Team	1 – 5 4	The ACT team has two Substance Abuse Specialists providing group and individual substance abuse treatment to members. SAS1 has several years experience in the same role on a previous ACT team. The SAS2 is a Licensed Professional Counselor who joined the team after three years as a child and family therapist; prior that that she worked with the adult population, primarily with	• Ensure that the SASs receive targeted training in substance abuse treatment delivery on ACT teams. Training should be ongoing and relate specifically to the co-occurring population.

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			individuals receiving general mental health services. The SAS2 also has seven years experience as a case manager for SMI determined individuals. Although many on the SAS2's previous caseloads carried substance use diagnoses, that area was not necessarily the focus of treatment. Although both SAS's resumes and lists of trainings were requested by the reviewers, none were provided.	
H10	Vocational Specialist on Team	1 – 5 4	The ACT team has two Vocational Specialists, a Rehabilitation Specialist (RS) and an Employment Specialist (ES). The RS said that she served in the same capacity on another ACT team. The RS reported attending quarterly vocational meetings held by the RBHA, and has received training in disability benefits through DB101 and the Ticket to Work and Freedom to Work programs. The ES joined the ACT team in January 2017 and moved into her current role after being hired as a "Specialist". Prior to that, the ES served as the SAS on the Comunidad ACT team. She also served in that role with another provider organization where she also worked with Vocational and Rehabilitative Services (VR) to assist members in finding employment. Beginning in 2015, the ES worked for less than a year as a job developer for an employment services agency helping SMI/COD diagnosed individuals obtain jobs. The ES has not received any employment specific training since joining this ACT team. The reviewers asked for copies of resumes and lists of relevant trainings but none were provided. Although both vocational specialists had previous experience on ACT teams it was not clear they had	• The RS and the ES should receive training and mentoring in working with SMI members find and retain jobs in integrated settings. Training attention should be given to developing relationships with employers in order to develop knowledge of area industries and job leads, as well as providing follow along and on-site job supports. The RS and ES should develop the necessary vocational skills to cross train other specialists on the ACT team.

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			received necessary training and experience in their respective roles.	
H11	Program Size	1 – 5 5	The ACT team consists of 11 full-time staff, including the Psychiatrist and is of sufficient size and staffing diversity to provide for the needs of its 77 members.	• The ACT team should maintain its current size as it continues to fill its roster.
O1	Explicit Admission Criteria	1 – 5 5	The ACT team uses the RBHA ACT Admission Criteria Screening Tool to assess members for program entry. Any of the ACT staff specialists may conduct screenings. The CC said that referrals originate from the RBHA, hospitals, Probation Officers, externally from other providers, and from internal clinical teams. Upon receipt of a referral, a Specialist goes out and conducts the screening using the tool and provides the individual with information about participating in ACT services. If the person is interested, the specialist then meets with the rest of the team to present information on the individual. The team discusses the appropriateness of the referral, and the Psychiatrist makes the final recommendation on admission. If the person is accepted on to the team, then he or she is invited to meet the team and an intake is scheduled. Staff reported that they are not under any pressure to accept members who fall outside the admission criteria, and that they are scheduling screenings at a steady rate. Those individuals leaving psychiatric hospitals are seen within 24 hours of referral, while other referrals must be seen within seven days.	
O2	Intake Rate	1 – 5 5	At the time of the review the ACT team was below census, with 77 members. The ACT team had accepted 31 new members in the six months prior to the review: October (6), November (3),	

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			December (5), January (5), February (6), and March (6). The CC said that the team does not accept more than six members in any given month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management services, the ACT team is fully responsible for all psychiatric services, vocational/employment services, substance abuse treatment, and individual counseling and psychotherapy. The team does not refer members to outside providers and staff verbalized the understanding that ACT teams are responsible for all services. The ES is currently working with seven members to find employment, assisting them with resumes, identification of relevant skills and experiences, and mock interviews. The ES said job searches are focused on those in integrated settings. The SASs provide members with two co-occurring groups weekly, and each provides members with individual substance abuse counseling. The SAS2, who is a licensed LPC, reported training in Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and Eye Movement Desensitization Therapy (EMDR) and appeared knowledgeable of trauma informed approaches to providing care to individuals diagnosed with SMI and co-occurring disorders. Because approximately 14% of members reside in a setting where they may receive some level of case management, the team could not be given credit for full responsibility for housing services. A few members may receive housing support from outside providers. Staff said that many of those individuals came to the team already placed in those living situations or with housing supports already provided; the teams's goal is to move most	• As the designated PSH services provider, the ACT team, to the extent possible, 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.

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			of them back into the community. A minority of members are in placements that are mandated by guardians or conditions of probation/parole.	
O4	Responsibility for Crisis Services	1 – 5 4	Staff interviewed said that the ACT team is responsible for crisis services 24 hours, seven days a week, including holidays. The on-call phone rotates daily with a primary staff and a back-up staff person on-call. The CC is responsible for managing calls that come directly into the clinic since the ACT team currently is without a PA. Copies of on call and secondary on call phone numbers are supplied to members on business cards. The cards also list the names and phone numbers of each specialist. The CC reported that he goes out into the community to meet with members in crisis when necessary; the CC was able to provide a recent example. Members interviewed reported that ACT staff are easy to reach by phone after 4 p.m. until 9 a.m. but generally difficult to reach during regular business hours. One member remarked that this could be a concern if someone was in crisis during the day.	• Members will not use the ACT team as their primary first responder if they are unable to reach the team when they are most needed. Identify and implement solutions that may inhibit crisis response during business hours. Filling the vacant PA position may bring some resolution to timely response to incoming crisis calls.
O5	Responsibility for Hospital Admissions	1 – 5 3	Ideally, members who express symptoms of concern or who are requesting a psychiatric admission are seen in the clinic by the Psychiatrist. When members go to the hospital voluntarily, a specialist should transport them to the hospital, remain with them through the admission process, and begin making contact with inpatient staff to begin discharge planning. Per review of the last ten psychiatric hospitalizations conducted with the CC, the reviewers found that the ACT team was directly	• Identify barriers to, as well as factors that contribute to, members self-admitting without consultation with the ACT team. Consider trust and rapport building as possible solutions that foster partnerships focused on recovery in the community supported by natural supports and accessible resources. • Work with each member and their support network to discuss how the team can support members in the community to

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			involved with 60% of admissions. The CC attributed this to some members not seeking hospitalizations through the team but instead admitting themselves or being admitted by a family member. The CC said that when this occurs the team usually learns about the hospitalization within 24 hrs. The CC also said that some members who were originally admitted to the hospital for their physical health were transferred to psychiatric units upon presentation of psychiatric symptoms.	avert, or to assist in a hospital admission, if the need should arise. Develop plans with members in advance, especially if they have a history of admitting without informing the team, etc. • See Recommendation for Item O4, Responsibility for Crisis Services.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff reported that hospital discharge planning begins at the time of admission when staff make contact with the hospital social worker and inpatient Psychiatrist. The ACT team and social workers make plans for aftercare, including where the member will live after discharge. ACT staff are alerted as to pending discharges and staff pick up the member from the hospital and take him or her home or to whatever living situation has been arranged. Along the way staff helps the member collect prescriptions from the hospital, groceries, or other needs. The Nurse and ACT Psychiatrist see the member within 72 hours of discharge. If the member's PCP is the team FNP, then the FNP would see the member in 72 hours as well. The ACT team begins a five-day face-to-face follow up schedule the day after discharge, which may be conducted at the member's residence or at the clinic. Per a review of the last ten psychiatric hospital discharges with the CC, the ACT team was directly involved in nine. In the one admission the ACT team had not been involved with, the member had originally been admitted for medical issues and	• The ACT team should continue efforts to coordinate all psychiatric discharges with hospital staff, and, to the extent possible, family who may be involved in providing the member support and care once returned to the community. • The agency should consider coordinated marketing and educational efforts toward hospital staff who may not be aware that the agency is now providing ACT services.

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			later transferred to the psychiatric unit. Even though the ACT team had been in contact with the hospital social worker and a *doc-to-doc* conversation had occurred, the hospital discharged to the family without consulting with the ACT team. This concerned the team because the team believed that the family home was not conducive to recovery.	
O7	Time-unlimited Services	1 – 5 5	Data provided to the reviewers showed that four members (5%) graduated with significant improvement from the team in the last 12 months. Staff said that members graduate when they rarely request or need services; are functioning well in the community without crisis calls or psychiatric hospitalization; have maintained stable housing; and are engaging in meaningful activities, including participating in volunteering, peer run programs, education, or employment. Staff said that members who graduated initiated discussion of stepping down to a lower level of care. The ACT team does not ween members off services but moves forward with the transfer and coordinates with the receiving clinical team. Staff said that members can decline step-downs, however, and remain on the team as long as they desire. The CC reported that he can think of two members who are likely to graduate in the next few months and does not anticipate any more than a total of five graduations by next year.	
S1	Community-based Services	1 – 5 4	Staff interviewed reported that they spend approximately 80% of their time providing services to members in the community. Per the record review, the ACT team was found to provide services in the community 79% of the time, including: medication observation and education,	• Continue efforts to deliver services in the community where challenges are most likely to occur. As the team reaches full census, the team should consider options for successful delivery of services primarily

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			support with independent living skills, individual substance abuse treatment, staffings, grocery shopping, jail visits, support at Mental Health Court and intakes with the housing voucher administrator. Members report that the team offers many clinic based groups and that there are plans to develop more. Members described some group activities of questionable benefit, such as coloring for an hour.	in the community. A review of strategies used by teams that have scored well in this area may be helpful. The hiring of a PA may open up more of the CC's time to see members in the community as well. • Substance use treatment groups are likely to occur in the clinic, but if other group interventions are developed, ensure they occur in the community settings that are relevant to skill building and recovery goals of the members.
S2	No Drop-out Policy	1 – 5 5	Per data provided, the ACT team was unable to retain one member who would not engage with the team. The CC did not have details about this case due to this occurring prior to his joining the team. Other staff interviewed also reported that no cases had been closed due to refusal to engage or lack of contact since they had joined the team. Four members left the geographical area with referrals, and three were closed due to being incarcerated for more than six months. Of those three members, one will soon be reopened upon release.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The CC described a client-centered approach to outreach and engagement that focuses on the member's wants and needs and may last nine weeks for difficult to locate or engage members. The CC said that engagement attempts must be relentless and creative, and often involve collaborating with other service agencies such as payees and legal approaches such as Probation Officers or the police when the member is court ordered to treatment. Per the CC, staff check in with hospitals, shelters, the morgue, and the members' preferred locations. If the member has	• Assertive engagement strategies that include legal mechanisms and street outreach are necessary to ensure the engagement of the most difficult to reach members. Formalize a written outreach protocol that incorporates a timeline/checklist of outreach activities recommended over the course of the outreach period, so that the strategy is consistent and understood over time as new staff enter the team. Ensure that all staff are provided a copy of the outreach

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			signed a release of information (ROI), staff will outreach the members' natural/informal supports for assistance in making contact. Staff provided the reviewers with the RBHA's specific contact guidelines for outreach and engagement. Members missing should be outreached by the team four times a week for eight weeks; if not located, the member is closed from ACT due to lack of contact unless the team Psychiatrist directs continued outreach. The guidelines did not provide specific outreach activities. In two records reviewed there was no outreach for members who were not in contact with the team for a week or more, including one member who discharged from an inpatient setting.	strategy.
S4	Intensity of Services	1 – 5 3	Staff provided the reviewers with written guidelines for clinical contact, which appear process oriented, stating that members should receive "120 minutes of direct face-to-face contact delivered each week (high fidelity if clinically indicated; if a member does not need high fidelity please document in their service plan)." The guidelines state that staff should aim for 30 minute visits according to clinical need; case management contacts may be 15 minutes or less, while counseling or skill development might be more. Per the record review, members receive an average of slightly over 76 minutes of contact with staff per week.	• In seeking to achieve an average of two hours of face-to-face service weekly for each member, it is recommended that staff maintain focus on building strong therapeutic relationships in which members are willing to commit their time and efforts to collaborate on gaining new knowledge and insights, developing skills and obtaining resources for achieving recovery goals that reflect their values and priorities.
S5	Frequency of Contact	1 – 5 2	The ACT team's written clinical contact guidelines align with the EBP protocol of an average of four contacts weekly per member. However, per the record review, members received an average of 1.88 contacts with staff weekly, and only two members averaged four or more contacts a week. As noted in Item S1, Community-based Services,	• Increase frequency of contact to an average of four contacts per week for each member. Contacts should be purposeful, person-centered, and recovery oriented. Ensure that group activities are not being developed just to meet fidelity contact

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			the ACT team holds a number of groups, which may be used to meet contact requirements.	requirements. • See Recommendations for S1, Community-Based Services, and S4, Intensity of Services.
S6	Work with Support System	1 – 5 1	The ACT team's written protocol suggests that outreach to informal supports be assigned to one staff weekly to ensure an average of four contacts per month for each member with an informal support. Staff reported that 70% of members have some type of natural or informal support system, and that staff have at least one contact with a natural support for each member about every other week. Staff said that when possible they try and involve informal support in staffings and service plan changes. The team also holds a weekly Friends and Family Group that meets each Monday, although attendance is low. Staff said that the PSS is helpful in working with informal supports. Two members interviewed reported that the team has regular contact with family members, including family therapy. The record review, however, showed just .3 contacts per month.	• Increase contacts with informal supports to an average of four per month for each member with a support system. As much as possible, contacts with informal supports should occur during the natural course of services provided to members. • Continue efforts to include informal supports as necessary members of the team. Technical assistance to refine strategies for engagement of informal supports may be useful.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Per staff report, 48 ACT members are diagnosed with a co-occurring disorder. The SAS1 and the SAS2 said that they provide structured, individual substance abuse treatment to all 48 members with a COD. The SASs said that members are seen weekly for approximately 30 minutes, usually in members' residences, and that most are seen four times monthly. In records, the reviewers found some evidence of individual substance abuse treatment. Of the seven members with a substance use issue, four received individual treatment, but only one had weekly sessions.	• Continue efforts to provide at least 24 minutes of substance abuse treatment to all members diagnosed with a COD.

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			Sessions appeared to be structured around each member's identified stage of change, and the SAS2's documentation showed use of trauma informed approach to COD treatment, including Eye Movement Desensitization Reprocessing (EMDR). The SASs reported that their sessions are scheduled on the electronic calendars; although the reviewers requested copies, those were not provided.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The ACT team provides two co-occurring treatment groups to the 48 members with a COD each week. The SAS1 facilitates the Early Recovery Group, which is geared toward members in the pre-contemplative to preparation stages of change. The SAS1 said that the group follows the curriculum developed by the RBHA. The SAS2 facilitates the Seeking Safety Group, which is for members in preparation to maintenance stages of change, with an emphasis on trauma informed practices. The SAS2 said that the curriculum (which was requested but not provided to the reviewers) was developed by a Psychiatrist renowned in trauma based healing and was approved for use by the RBHA. The SASs described using evidence based approaches such as Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and motivational interviewing (MI) as part of their treatment approach. The SAS1 reported that about 35% of the 48 members with a COD attend the Early Recovery group at least once monthly, and that approximately 16 attend regularly. The SAS2 said that about 35% of the 48 COD diagnosed members attend the Seeking Safety group at least once monthly, and that six – eight members attend on a	• Continue efforts to increase co-occurring group participation to 50% of members with a co-occurring disorder. • In keeping with the team's use of trauma informed care approaches, consider offering daily COD groups for members with specific cultural and identity concerns such as COD groups for bilingual or indigenous members and COD groups that are gender specific or members who have an LGBTQ status.

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			regular basis. The SASs said about 25% of COD diagnosed members attend both groups. The record review showed that of the members diagnosed with a COD, 29% attended at least one group in a 30 day period.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The ACT team reports following the Co-occurring Disorders Model but interviews and records suggest more of a mixed model. Co-occurring groups appear designed to target members with specific stages of change; and documentation of individual sessions provided some evidence of interventions that align with specific stages of changes. For example, one member in maintenance stage was provided relaxation techniques and cognitive behavioral therapy (CBT) interventions to cope for stressful situations that trigger cravings to use substances. The SASs said they have a role in educating the team on harm reduction strategies which emphasize reducing the frequency and intensity/lethality of use. Additionally, staff said they receive weekly, monthly and annual trainings and supervision on substance abuse from the ACT Manager and the RBHA. The SASs do not refer to Alcoholics Anonymous/Narcotics Anonymous groups unless requested specifically by members. Detoxification programs are used only when the Psychiatrist determines them to be medically necessary. The SASs said that alcohol and benzodiazepines present the greatest risk that may make detox appropriate. However, other staff reported marijuana and methamphetamines as substances leading to a detox referral.	• The agency and the RBHA should continue efforts to train and support all ACT specialists in the co-occurring model, including a stage-wise approach. Staff trained in the stage-wise treatment approach, specifically the team SASs, should provide periodic job shadowing and mentoring to model and provide feedback about stage-wise interventions and co-occurring treatment principles. • ACT specialists should periodically sit in on COD groups to further their knowledge of the co-occurring model, as well as develop skills in implementing a stage-wise treatment approach with members when delivering services in other settings. • Retaining existing trained staff and supporting cross-training from the two qualified SASs may expedite the ACT team becoming fully based in the co-occurring model.

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			Interviews with staff showed awareness of stages of change, harm reduction, and motivational techniques but how they are integrated under a stage-wise treatment approach appeared inconsistent across staff. Additionally, how staff embrace the COD model may not be universal across the team. One record showed a staff member requiring compliance with treatment recommendations as a prerequisite to follow through with service requests and assistance.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has a Peer Support Specialist who is a full member of the team with responsibilities equal to those of other specialists. The PSS was actively engaged in the program meeting observed by the reviewers and described by the CC as essential in outreach to informal supports.	
Total Score:		**3.89**		

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	2
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	4
10. Vocational Specialist on Team	1-5	4
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	4
5. Responsibility for Hospital Admissions	1-5	3

6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	1
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	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.89**	
Highest Possible Score	**5**	