ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with Western Interstate Commission for Higher Education Behavioral Health Program to conduct Fidelity Reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an evidence-based practice (EBP).

Method

On November 15 - 16, 2022, Fidelity Reviewers completed a review of the Lifewell Behavioral Wellness South Mountain ACT team. This review is intended to provide specific feedback in the development of your agency's ACT services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Lifewell Behavioral Wellness offers residential, outpatient, and community living programs to persons diagnosed with a serious mental illness, general mental health issues, and/or substance use disorders. Some of the services Lifewell offers include integrated health care, outpatient counseling, psychiatry services, case management, psychosocial rehabilitation, and housing. The individuals served through the agency are referred to as "clients" or "members", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to interview staff and members.

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

- Remote observation of an ACT team program meeting on November 15, 2022.
- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with Housing, Employment, ACT, Independent Living, and Peer Support Specialists.
- Individual phone interviews with five members participating in ACT services.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; resumes and training records for Vocational Specialists and ACT Specialist; *Lifewell ACT South Mountain Brochure*; *8-week Outreach Checklist*; sign in sheets for co-occurring disorder treatment groups for the month prior to the review; copy of *Dartmouth Integrated Dual Disorders Treatment Manual* cover page utilized for co-occurring disorder treatment; *ACT CC Face to Face hours* for the month prior to the review; member calendars for the month prior to the review; and ACT team member roster identifying members with a co-occurring disorder and members with a natural support.

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

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team is of sufficient size to provide the necessary coverage to the 94 members served. The team has an appropriate member to staff ratio of 10:1.
- The Psychiatrist attends program meetings four times per week and spends one day a week providing services to members in community settings.
- Staff is available to provide crisis support, including weekend coverage. Team specialists rotate on-call coverage and meet members in the community.
- The team-maintained consistency and continuity of care for members with a low admission and drop-out rate for the period reviewed.

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

- Attempt to identify factors that contributed to staff turnover, or, conversely, support retention. During the year prior to review some positions were vacant for multiple months.
- Increase support to members that receive a lower intensity and frequency of service. The ACT team should provide members an average of two hours of in-person service time and an average of four or more contacts weekly.

- Optimally, ACT services are delivered in the community where challenges are more likely to occur. It will be beneficial to shift the locus of service from the office to the community.
- Increase engagement with natural supports as partners in supporting members' recovery goals. Training staff on strategies for engaging informal support may be helpful. Staff may then be able to advise natural supports on how they can reinforce healthy recovery behaviors or use recovery language when they interact with members.
- Provide training, ongoing guidance, and/or supervision to staff in a comprehensive integrated co-occurring disorder stage-wise treatment model developed for members with co-occurring SMI and substance use diagnoses.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, there were nine full-time equivalent (FTE) staff, excluding the Psychiatrist, providing direct services to 94 members. The team has an appropriate member to staff ratio of 10:1. The team is comprised of the Clinical Coordinator (CC), Employment Specialist (ES), Housing Specialist (HS), Independent Living Specialist (ILS), Peer Support Specialist (PSS), Rehabilitation Specialist (RS), ACT Specialist (AS), and two Nurses.	
H2	Team Approach	1 – 5 3	Staff interviewed reported 70 - 80% of members have contact with at least two ACT staff each week. It is unclear per staff interviews if the team follows a strategy to ensure all members have in-person contact with more than one staff over a two-week period. Some staff reported carrying a caseload for administrative purposes only. However, other staff reported meeting with their assigned caseload and a rotating assignment of regions weekly to ensure members are seen by different staff. Another staff reported mainly meeting with only their assigned caseload weekly. Based on review of ten randomly selected records, 50% of members received in-person contact with more than one staff in a two-week period. Three of five members interviewed reported seeing more than one staff in a two-week period.	• Increase contact of diverse staff with members. Team staff are jointly responsible for making sure each client receives the services needed to support recovery from mental illness. Diversity of staff interaction with members allows the members access to unique perspectives and expertise of staff, as well as the potential to reduce burden of responsibility of member care on staff. • Ideally, 90% of ACT members have contact with more than one staff in a two-week period. Consider options to increase contact to members according to the goals identified in individual service plans.

H3	Program Meeting	1 – 5 5	ACT team staff interviewed reported that the team meets Mondays, Tuesdays, and Thursdays. On Wednesdays the team meets for an additional hour to review "at risk members". In addition, on Fridays the team attends a "huddle" to review staff schedules for the day and are informed of members that need to be seen over the weekend. All members on the ACT team roster are discussed during the program meeting. All staff are expected to attend the program meeting when scheduled, including the Psychiatrist. During the program meeting remotely observed, the program assistant led the discussion by reviewing all members on the ACT roster utilizing member calendars and reported on members' stage of change for those with a co-occurring disorder. Staff, including the CC provided input on recent member and natural support interactions including attempts, and planned contact for the week. The Psychiatrist provided recommendations and direction to the team on engaging members in employment, peer run activities, individual and group co-occurring disorder treatment, and discussed coordination of care with inpatient providers. In addition, one non-ACT staff was present that asked for additional details from staff pertaining to members' care and delegated tasks.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated delivering in-person services to members 30% of the time. The CC reported carrying a caseload, participating in the weekly region rotation seeing members in the community, accompanying the Psychiatrist once	• Optimally, the ACT CC delivers direct services to members and should account for at least 50% of the expected productivity of other ACT staff. ACT leaders that have direct clinical contact with members are better able to

			a week in the community for appointments, and meeting with members at the clinic. Reviewers requested a productivity report for the CC for a recent month period, however, was only provided the number of total hours for in-person encounters for a recent month. Data provided showed less than 10% of the CC delivering direct services. Two of the members interviewed reported seeing the CC recently. Review of ten member records did not show evidence of the CC delivering in-person services to members.	model appropriate clinical interventions to staff and remain in touch with the members served by the team. • 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. • Ensure all services delivered to members of the ACT team are documented in member records.
H5	Continuity of Staffing	1 – 5 1	Based on data provided, 18 staff left the team since the last review (February 2021), resulting in a turnover rate of 90%. Per interview and data reviewed with the CC, Co-Occurring Specialist (COS) positions were the most difficult to retain with six leaving the team during this time frame. Members interviewed expressed services could improve by consistent staffing. One member interviewed reported frustration with the team's turnover rate as they are having to "explain my story" to new staff repeatedly. Another member expressed concern with staff "overworked and overloaded" and how that affects stability for member care and services delivered, such as communicating member needs to the Psychiatrist.	• ACT teams should strive for a turnover rate of less than 20%. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff. • If not already done so, examine employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention.

H6	Staff Capacity	1 – 5 3	Per data provided and reviewed with staff, the ACT team had 45 vacancies in the 12 months prior to the review and operated at 69% staffing capacity. The team had 12 months without a second COS on staff, five months without any COS, and eight months without a PSS.	• Ensure staff receives training and guidance applicable to their specialty position. Research shows staff remain in positions longer when supported in their roles. • Ideally, ACT teams operate at 95% or more of full staffing annually.
H7	Psychiatrist on Team	1 – 5 5	The team has one FTE Psychiatrist that works four 10-hour days Monday - Thursday and attends the program meeting on those days. Staff reported the Psychiatrist only sees members of this ACT team and is accessible to the team in person, by phone, and email, including after hours and weekends. Staff reported the Psychiatrist provides services at the clinic, by telehealth, and spends one day a week in the community. Members interviewed reported seeing the Psychiatrist monthly at the clinic or in their home.	
H8	Nurse on Team	1 – 5 5	The team has two Nurses that work Monday through Friday. Both Nurses attend all program meetings, including the Friday team huddle. Staff reported the Nurses are readily accessible to the team by phone, email, in person and are available after hours. Nurses provide medication education, administer injections, complete lab draws, triage members in crisis, and primary care physician and inpatient hospital staff coordination. Both Nurses provide services in the community twice a week. Members interviewed reported meeting with the Nurses at varying frequencies (every other week or monthly) at the clinic or in their home.	
H9	Co-Occurring Specialist on Team	1 – 5 1	At the time of the review the team had both COS positions vacant. However, staff reported that	• ACT teams should have 2 COS. When screening potential candidates for the position, consider experience working with members with co-

			the team is in the process of transitioning a current staff into a COS position.	occurring disorders and delivering services in integrated care settings. Once the positions are filled, ensure staff are provided annual training, at a minimum, in co-occurring treatment best practices, including appropriate interventions, i.e., stage wise approach, based on members' stage of change. COS should be provided supervision from a qualified professional.
H10	Vocational Specialist on Team	1 – 5 5	The team has two Vocational Specialist staff. The Employment Specialist joined the team in December 2021 and the Rehabilitation Specialist joined the team in October 2022. Based on resumes provided, both VS staff have more than one year of experience in providing services and supporting adults with a serious mental illness in rehabilitation or employment services. Records provided show the ES completed over five hours of vocational related training and topics including motivational interviewing in the past two years, although all relevant training was completed at the time of onboarding with the team. The RS had three hours of vocational related training in the past two years. It is unclear if either VS are attending Rehabilitation and Employment trainings with Mercy Care and/or Vocational Rehabilitation.	• Ensure ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid members diagnosed with SMI/co-occurring diagnoses to find and retain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, employer engagement, and follow-along supports.
H11	Program Size	1 – 5 5	At the time of the review, the ACT team was composed of ten staff including the Psychiatrist. The team is of adequate size to provide coverage to the 94 members. Vacant positions include both COS.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team has a clearly defined target population. Based on interviews with staff, the team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. Staff	

			reported members are referred by the Regional Behavioral Health Authority, other teams within the agency, and other providers. Staff reported the CC, and an ACT staff conduct screenings of members referred, and that all ACT Specialists are trained to complete the screenings in person or over the phone. The CC coordinates with the referring agent, and a doctor to doctor occurs with the team's Psychiatrist for additional information. The potential member is reviewed with the entire ACT team and then the Psychiatrist makes the final decision if the member is appropriate for the team.	
O2	Intake Rate	1 – 5 5	Per the data provided, and reviewed with staff, the ACT team admitted seven members in the last six months prior to the review. This rate of admission is appropriate as there were never more than two new members admitted in a month.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the ACT team directly provides psychiatric and medication management, and housing support. Based on staff interviews, the team provides housing supports to members. At the time of the review staff reported nine members were in need of housing. The team had less than 10% of members residing in settings where there was a duplication of ACT services. One member record reviewed showed the Psychiatrist speaking with a landlord to halt a possible eviction and advocating for the member. Based on interviews with staff, members receive counseling/psychotherapy services from a Licensed Independent Substance Abuse	• Counseling/psychotherapy should be available on ACT teams. Consider options to include staff on the team that can provide individual counseling to members. • Ensure members receive individual and group co-occurring disorder treatment by ACT staff. Members benefit when services are integrated into a single team, rather than being referred to a non-ACT staff or different service providers. • The team should fully assume responsibility for assisting members with the process of finding and maintaining employment in integrated community settings according to the member's preferences rather than refer them to a work adjustment program outside the ACT team.

			Counselor at the agency and two members receive counseling services from another agency. In addition, the team utilize agency staff off the ACT team to provide individual and group co-occurring disorder treatment. Member records reviewed showed evidence of non-ACT staff providing co-occurring disorder treatment groups. Based on staff interviews, the team helps members with resumes, job development activities, and ongoing support to obtain and maintain employment. Staff indicated seven members were actively engaged with the team in job search activities and approximately twelve were reported as being competitively employed. Records reviewed showed evidence of staff engaging members in conversation related to employment, assisting with obtaining a fingerprint clearance card, and providing one member with technology assistance at the member's home for online job search. However, 2 – 6 members are enrolled in a work adjustment program outside the ACT team.	
O4	Responsibility for Crisis Services	1 – 5 5	Per interviews with staff, the team provides 24/7 crisis services to members of the team. Staff reported the team rotates on-call responsibilities weekly and the CC serves as the back-up. Staff indicated the team will assess the situation with the member by phone, attempting to deescalate, and if there is a need to meet the member in the community, staff will contact the CC to advise for safety purposes. Members are provided the *Lifewell ACT South Mountain Brochure* that consists of the ACT on-call number along with all ACT team staff contact information. Members	• Ensure members are provided with the ACT on-call number. Some teams provide this on a business size card which also includes staff names, roles on the team, and phone number. Consider assisting members in saving the on-call number on their phones.

			interviewed were aware of the team's on-call services. However, two members reported not having the number, one member stated they would contact their assigned case manager, and another member indicated they would call law enforcement if they needed assistance after hours.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Based on data provided and reviewed with the CC, the ACT team was directly involved in 40% of the most recent psychiatric hospital admissions. The team reports when members express a desire to be psychiatrically hospitalized, the team will attempt to have them triaged by the ACT Psychiatrist or Nurses, and if the recommendation is for inpatient care, the team will ask the member which hospital they prefer. The team will transport the member, coordinate with the inpatient team providing a medication flow sheet, at risk crisis plan, and contact information for the clinical team. ACT staff will wait with member until admitted. Staff indicated the team will coordinate with the inpatient team every 48 hours, doctor to doctor calls occur every 2 – 3 days, and staffings are held with members once per week. Staff reported that limited hospitals are allowing in-person staffings, and as an alternative to face-to-face meetings, staffings are completed via phone, or videoconferencing. Based on data provided and reviewed with the CC, five members self-admitted, and one member was petitioned by a natural support without the team's knowledge. One member record showed staff participating in a staffing with the inpatient team three days after self-admitting. However, one member record did not	• Maintain regular contact with all members and their support networks. This may result in early identification of issues or concerns that could lead to hospitalization allowing the team to offer additional supports which may result in a reduced need for hospitalization. • Evaluate what contributed to members not seeking team support prior to self-admissions. • Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions. • Consider if member treatment plans should be revised to address behaviors and/or circumstances related to self-admissions.

			show documentation of coordination with the member or inpatient team for seven days while inpatient.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff interviewed identified following a five-day follow up protocol with members upon hospital discharge that includes in-person contact daily for five days. Staff transport each member when discharged to the clinic, pharmacy, and place of member's choosing. The member is scheduled to meet with the Psychiatrist within 48 hours, and the Nurse within seven days of discharge. Based on data provided for the ten most recent hospital discharges and reviewed with staff, the team was directly involved in all ten. Of the ten most recent psychiatric hospital discharges, the team transported nine members from the hospital, one member refused to be transported by the team when the team arrived to discharge. Per report, 8 out of 10 members met with the Psychiatrist, and 4 out of 10 met with the Nurse within the protocol timeframe reported. 3 out of 10 members were seen by the team for the five-day follow up. During the program meeting observed, staff discussed members that were inpatient, and a few were discussed on discharging and the staff that was going to discharge. However, five-day follow up that occurred or will occur was not discussed. However, a review of member records showed that one member was discharged by the team and transported to a placement. Although the	• Ensure the team delivers post psychiatric hospitalization follow up services and supports as discussed in interviews. During the program meeting, consider identifying the ACT staff responsible for contact on that day and track on member calendars.

			member did attend the Psychiatrist appointment, it was five days after discharge. The member did attend the Nurse appointment seven days after discharge but was not seen in-person by the team until the fourth day after discharge. In another record, a member was discharged, attended the Psychiatrist appointment three days later, and the Nurse appointment four days after discharge. Other than appointments with the Psychiatrist and Nurse, there was no evidence in the chart the member received in-person five-day follow up by the team. In addition, the member was back and forth from residential placement, emergency room and psychiatric hospital, and not seen by the team for at least 26 days.	
O7	Time-unlimited Services	1 – 5 5	Data provided to reviewers showed the ACT team graduated two members over the past year. Staff interviewed reported that the team anticipates graduating one member in the next year.	
S1	Community-based Services	1 – 5 1	All staff interviewed reported that 80% of in-person contacts with members occur in the community. However, the results of ten randomly selected member records reviewed show the ACT team provided services a median of 3% of the time in the community. Per the review of ten randomly selected member records, five had at least one contact in the community documented. Of the five records, community-based services occurred at members' homes, hospitals, and during transport. Three records documented contact in the member's residence where medication delivery, well-check	• ACT teams should deliver 80% or more of their contacts in the community where staff can directly assess member needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting.

			home visits, vocational service, and independent living skills training were provided. Per member interviews, three reported meeting with staff at their home. One member reported not seeing staff at their home as often as they used to, indicating they do not like to wait around all day for staff to arrive and another member reported staff do not come to their home based on member preference. One member expressed that a barrier to home visits is that staff arrive unexpected while member is not home. The member suggested a scheduled time would ensure member availability.	
S2	No Drop-out Policy	1 – 5 4	According to data provided, a total of 18 members dropped out of programming with the team resulting in 81% retention rate in the last 12 months.	• ACT teams should ideally retain 95% of the entire caseload year to year. Several factors can impact this number positively including admission policies, consistency in staffing, natural support involvement, assertive engagement practices, and taking a recovery perspective with member care.
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff interviewed reported utilizing an *8-week Outreach Checklist* for members on outreach. Staff reported outreach efforts occur four times a week, for eight weeks, with at least two attempts in the community. Staff reported efforts to engage and outreach includes phone calls to jails, probation officers, payees, natural supports, and electronically checking the Medical Examiner's Office. Physical outreach attempts to in the community include, shelters, parks, known hangouts, last known address, gas stations, or intersections where members frequent. Staff indicated that when members are disengaged from the team, the CC rotates assignments of staff to locate members each week.	• When members miss scheduled appointments or are not seen at the frequency of ACT services, ensure a team discussion occurs during the program meeting to plan follow up care and is documented in member records. • Ideally, outreach should be carried out by multiple ACT staff and documented in the member's record. • Monitor documented outreach and contacts with members. It may be useful to assign one staff to spot-check documentation in member records during the team meeting to confirm recent contacts or outreach efforts are documented. This may enable the team to

			During the meeting observed, staff discussed outreach attempts on several members using street outreach, contacting probation, and outreach to natural supports and guardians in attempts to reengage members. However, records reviewed did not indicate outreach and engagement efforts as described by staff. One member record reviewed showed outreach efforts did not occur for 12 days after the team learned the member was evicted, and only occurred once every seven days thereafter. Another member record showed two contacts by the team in the month period reviewed, once by phone. In addition, another member record showed outreach efforts only twice per week for four weeks, by the same staff, in the community and searching the Medical Examiner's Office and/or the Maricopa County Sheriff's Office database during the month period reviewed.	proactively assign staff to outreach in the event of lapses. • Ensure all outreach efforts, including letters, phone calls, and contact with formal and natural supports are documented in member records.
S4	Intensity of Services	1 – 5 2	Per a review of ten randomly selected member records, during a month period before the fidelity review, the median amount of time the team spends in-person with members per week was 40.50 minutes. The record with the highest weekly average was 222 minutes. Two of the ten records had zero in-person contacts.	• Increase the duration of service delivery to members. ACT teams should provide an average of two or more hours of in-person services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on their individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 2	Of the ten records randomly sampled, ACT staff provided in-person contacts across all members a median frequency of 1.13 contacts per week, with the highest frequency shown in one record of 7.75 contacts a week. Five of the records reviewed indicated less than one in-person	• Increase the frequency of contact with members by ACT staff, to the extent possible, preferably averaging 4 or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals.

			contact a week. Records indicated a median of one hour phone contact with members and no telehealth services delivered. *The fidelity tool does not accommodate delivery of telehealth services.*	Members may have different needs/goals and frequency of contact should be determined by those needs and immediacy. • Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to receive ongoing support. Improved outcomes are associated with frequent contact. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. Those contacts should be individualized and align with treatment goals identified in member plans.
S6	Work with Support System	1 – 5 2	Per data provided, 22 members were identified as having a natural support. Staff reported the team welcomes natural supports to member appointments and can attend any group with the member. Staff reported that the team will contact natural supports weekly by phone, email, or in-person if a release of information is on file. Natural support contact is documented on member calendars during the program meeting. During the meeting observed, natural support contact or attempts were identified for eight members. Based on the ten member records reviewed, there were zero contacts documented with natural supports. Members interviewed reported that the team does not have contact with their natural supports. One member reported living with their natural supports and the team does not interact with them.	• Continue efforts to engage members' natural support systems as key contributors to the member's recovery team. Staff should model recovery language and provide tips to family members and other natural supports how they can support member care. • 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. • 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.

S7	Individualized Co-Occurring Disorder Treatment	1 – 5 2	Per interviews and data provided, 66 members were identified with a co-occurring disorder. Staff reported approximately six members received individual co-occurring disorder treatment ranging from 30 – 40 minutes within two days prior to the review by the ACT Specialist that is transitioning to the COS position. Per *member calendars* for October 2022 shared with reviewers, five members received individual co-occurring disorder treatment. However, documentation does not indicate the staff that provided the service or the duration. Staff reported sessions are structured around, Integrated Co-Occurring Disorders Treatment (ICDT), harm reduction, and motivational interviewing strategies. Resources utilized by staff include *Dartmouth Integrated Dual Disorders Treatment Manual.* Five of the ten member records reviewed were identified by the team as members with a co-occurring diagnosis. The COS position was vacated at the end of October 2022. No member records reviewed showed evidence of individual co-occurring disorder treatment provided by the team in the month period reviewed. One record showed the Psychiatrist attempting to engage a member in individual co-occurring disorder treatment.	• Train staff on strategies to engage members in individualized treatment as appropriate, based on their stage of treatment. • Make available ongoing supervision by qualified staff to support the efforts to provide individual co-occurring disorder treatment by the team. • Ensure the average time spent in individual sessions is 24 minutes or more per week across the group of members with co-occurring diagnoses. • Consider tracking the frequency and duration of individual sessions on member calendars during the program meeting.
S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	Staff interviewed reported two co-occurring disorder treatment groups are facilitated by ACT staff to ACT members weekly. Staff reported approximately 12 - 16 unique members attend the groups weekly. Based on review of co-	• Optimally, 50% or more of members with a co-occurring 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

			occurring diagnosis treatment group sign-in sheets facilitated by the previous COS for the month prior to the review, 11% of ACT members with a co-occurring diagnosis attended at least one co-occurring disorder group. Staff reported recommending substance use treatment groups to all members with a co-occurring diagnosis. Of the five member records reviewed that were identified by the team with a co-occurring diagnosis, one attended three co-occurring treatment groups in the month period reviewed facilitated by ACT staff, in addition the same member attended co-occurring disorder treatment groups twelve times in the month period reviewed that was facilitated by non-ACT staff. The other four member records reviewed did not indicate staff engaging to attend co-occurring disorder treatment groups.	treatment groups based on their stage of change with content reflecting stage-wise treatment approaches. • Consider offering two groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach.
S9	Co-Occurring Disorders Model	1 – 5 4	All staff interviewed reported supporting members in reducing use of substances and gave examples of harm reduction tactics. In addition, staff reported utilizing motivational interviewing strategies. Staff reported encouraging members with a co-occurring disorder to participate in individual or group co-occurring treatment and indicated members treatment plan goals align with their stage of change attempting to "meet them where they are at" in their own recovery. Staff do not refer members to peer run substance use programs but will support members that request to attend. When members request detoxification services, the team will refer them to local resources.	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Co-Occurring Disorders Treatment, in the principles of a stage-wise approach to interventions, harm reduction, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new or less experienced staff. Identifying a co-occurring disorder model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in their recovery.

			Staff interviewed were not familiar with the principals of a stage-wise treatment approach to interventions. However, based on training records provided, staff have training hours completed in Integrated Dual Disorders Treatment (IDDT) modules. Staff indicated Relias is the only training offered to support the team in best practices for working with members with a co-occurring disorder. Based on records reviewed, of the five members listed on the COD roster, four members' treatment plans reflected goals to support the members in steps towards recovery. The member without steps identified, joined the team two months prior to the review and did not yet have a treatment plan. Two member records identified COD treatment goals but were not listed on the team's COD roster. One of those members had a documented co-occurring disorder diagnosis and goals to attend weekly individual co-occurring disorder treatment with the team and co-occurring disorder groups with an outside provider. The other member did not have a documented co-occurring disorder diagnosis, however the treatment plan indicated co-occurring treatment goals.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff interviewed reported that at least once staff on the team has lived psychiatric experience and shares their story with members when appropriate. Staff reported that the PSS offers insight to the team on services that were helpful to them in their recovery and provides the team with a perspective as a peer that help deliver services to members.	• Continue efforts to educate members, as applicable and appropriate, about staff on the team with lived experience that may serve as a resource.

			Of the members interviewed, three were not aware of staff on the team with lived psychiatric experience.	
Total Score:		**TOTAL 97**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	1
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	1
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	3
4. Responsibility for Crisis Services	1-5	5

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	1
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.46**	
Highest Possible Score	**5**	