ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 24, 2021

To: Kristina Adams, Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On April 19 – 20, 2021, Annette Robertson and Kerry Bastian completed a review of the Community Bridges, Inc. Forensic Assertive Community Treatment (FACT) Team 3. 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.

Community Bridges, Inc. (CBI) operates several locations throughout Arizona. Services include supportive housing, crisis stabilization, ACT, and integrated healthcare. The agency operates three ACT teams and three Forensic ACT (F-ACT) teams in the Central region of Arizona. This report will focus on the F-ACT 3 team located in South Phoenix. The Psychiatrist for this team provides all services via telehealth.

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 teleconferencing or phone contact to interview staff and members.

The individuals served through the agency are referred to as client, 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 via videoconference.
- Individual interviews with the Clinical Coordinator (CC), the Employment Specialist (ES), Substance Abuse Specialist (SAS), and the Psychiatrist.
- Individual phone interviews with three members receiving services from the F-ACT team.

- Charts were reviewed for ten randomly chosen members using the agency's electronic medical records system.
- Review of documents and resources including: Clinical Coordinator (CC) productivity report, *Mercy Care FACT Admission Criteria*, *F-ACT Screening* tool, F-ACT staff contact sheet, resumes and training records for the Substance Abuse Specialist (SAS) and vocational staff, resources used by the SAS, and the SAS calendar for one month and group sign-in sheets, and group sign-in sheets.

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:

- The team has a clear explicit admission policy. The CC, Clinical Lead, and Psychiatrist will discuss each referral and a decision is made collaboratively whether a referral is appropriate.
- The team provides 24-hour crisis services to members. In-person community support is offered to members after hours. The team provides phone support initially, and when necessary, will meet with members to assist them with their needs.
- The team provides direct support to members after being discharged from inpatient psychiatric care. A comprehensive plan to support members when they return to their community was described by staff.

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

- Several positions on the team (Nurse, SAS, and Vocational Specialist) are understaffed or filled by staff or interns with limited experience working in that specialty position or with members with a serious mental illness. The Evidenced-Based Practice (EBP) of ACT is designed for those members who are not successful in traditional behavioral health services. In addition, this particular team is focused on members with a criminogenic background and determined to be at risk of recidivism. Work to hire staff with a history of providing services to people with the unique characteristics of these members. Ensure training and supervision is provided for the specialty positions.
- The frequency and the intensity of delivery of services to members should increase. Improved outcomes are directly related to these two items.
- Provide training and guidance to the team in an effort to provide members with an integrated approach to mental health and substance use treatment services. 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 F-ACT specialists use when supporting members in their recovery.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, there were five full time equivalent (FTE) and two 50% staff on the team, excluding the Psychiatrist and Program Assistant. It was reported that there were 91 members on the team, leaving a member to staff ratio of 15:1. Some staff reported specialists on the team are working overtime in an effort to meet member needs.	• Agency leadership should prioritize filling open positions on the team to make certain a 10:1, or less, member to staff ratio exists. Small caseload size ensures adequate intensity and individualization of services to members and, perhaps more importantly for this team, minimizes the potential burden on staff.
H2	Team Approach	1 – 5 4	Staff interviewed report that at least 80% of members receive services from more than one F-ACT staff in a two-week period. Members with phones are receiving telehealth services from the team. The team assisted at least 10 members in obtaining free mobile phones in recent months. Staff also reported that recently some members utilized personal stimulus funds to obtain more technologically advanced phones. With assistance from the team, members were guided on how to download an application the team utilizes for videoconferencing. The team also assisted members in programming numbers of the F-ACT staff into phones and informed members where to call if they need further operational assistance. Members without access to phones, either come into the clinic monthly to attend their telehealth appointment with the Psychiatrist, or the team will meet them at their living situation and facilitate the call. One member interviewed reported normally only seeing one staff a week, another reported not seeing any the week before the review, yet another was excited to report seeing three staff the week before but that it was not typical.	• Under ideal circumstances, 90% of ACT members have contact with more than one staff in a two-week period. Consider options to increase contact while following public health guidelines. • 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.

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			Review of ten randomly selected records, from a period before the public health emergency, showed 70% of members received contact from more than one staff of the team. *The fidelity tool does not accommodate for telehealth services.*	
H3	Program Meeting	1 – 5 5	Staff interviews indicate the F-ACT team meets five days a week and the Psychiatrist attends all scheduled team meetings but Fridays. The Nurse attends days scheduled to work (4). The meeting observed by reviewers was well attended with only one staff person being absent as they were taking personal time off. All members were reviewed, and for most members, at least one staff commented relating to: last contact made, next planned contact in the community or in jail, upcoming court hearings and medical appointments, medication related concerns, hospitalizations, and stage of change, among other comments. The team did move to virtual program meetings when public health guidance suggested limiting contact with persons outside your household, but as restrictions have lifted, some staff attend from the office and others virtually, including the Psychiatrist.	• The ACT team should minimize the completion of administrative tasks in program meeting that distract from the team's focus on member needs and concerns, solve problems and engage in person-centered planning and recovery-oriented rehabilitation efforts.
H4	Practicing ACT Leader	1 – 5 2	During the past 12 months, the team has had four CCs. The CC currently in the position, for approximately two months, estimated spending 20% of their time in direct service with members of the F-ACT team and 60% of their time delivering telehealth. The CC reported completing all intakes for the team and will meet with members when they come into the clinic. By phone, the CC provides members with resources in the community, coordinating care, and noted that	• CC should provide direct services 50% of the time. Continue efforts to monitor and track CC direct services to members. Review CC administrative tasks to determine if any of those can be transitioned to other staff at the clinic or agency, allowing the CC more time to provide direct member services, to model interventions, and support the team specialists in their roles.

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			building rapport with members is more difficult when unable to meet in-person. Some members are still not comfortable coming into the clinic. Documentation sent to reviewers regarding actual CC in-person time spent with members for a month period just prior to the fidelity review showed 8% in direct service to members. During the program meeting observed, the CC reported meeting with members at their home the day prior, attending inpatient hospital and residential staffings virtually, among other activities. *The fidelity tool does not accommodate for telehealth services.*	• Ensure all activities are documented in the agency's electronic health record system.
H5	Continuity of Staffing	1 – 5 1	Data provided to reviewers showed that at least 25 staff left the team during a two-year period before the review, resulting in 104% turnover. Six staff started with the team at the beginning of this year. The Nurse, CC, and Housing Specialist positions had the highest turnovers at three each. Two members interviewed expressed concern with the high turnover of staff on the team. One of those members expressed consideration of transferring to another team due to the high turnover of staff. Another member stated that staff "quit" the team to take other positions at the agency.	• Continue efforts to hire and retain qualified staff, including working with administration to thoroughly vet candidates to ensure they are the best fit for the position and the demands of an ACT level of service. ACT teams should strive for a turnover rate of less than 20%. Maintaining consistent staffing supports team cohesion and reduces potential burden on staff. • The agency should identify contributing factors to high staff turnover and work to find solutions. Consider anonymous employee satisfaction surveys to gather and analyze data and implement practices to improve retention. Technical assistance is advised in this area.
H6	Staff Capacity	1 – 5 3	In the past 12 months, the F-ACT team operated at approximately 77% staffing with a total of 33 vacancies. The Independent Living Specialist	• Fill vacant positions as soon as possible to ensure diverse coverage. Maintaining consistent staffing offers members an array

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			position and one Nurse position had the highest vacancies. Two members interviewed commented on the lack of staff on the team and suggested that it has impacted services.	of staff with multi-disciplinary training and experience to address their needs. Also, timely filling of vacant positions helps to reduce potential burden on staff.
H7	Psychiatrist on Team	1 – 5 4	The Psychiatrist has been working with members of this team for two and a half years. Members are scheduled at least monthly for telehealth appointments and more frequently when needed. The team has access to the Psychiatrist by phone and email to answer questions about medications, to triage a case when a member is experiencing an increase in symptoms and provides clinical context when member issues arise. The Psychiatrist provides services through telehealth 30 hours a week and is available to the team outside of those hours as needed.	• Increase the Psychiatrists time assigned to the team to 100%. ACT is designed for members that are not successful with traditional case management and require a higher level of service. Availability of a full-time psychiatrist helps ensure members and staff have adequate access to the clinical expertise of the Psychiatrist.
H8	Nurse on Team	1 – 5 2	At the time of the review, the team did not have a full time Nurse assigned to the team. Staff interviewed reported that the team is currently sharing a Nurse with another ACT team, equating to a 50% staffed position for 91 members. The Nurse works four days a week, is available to the team by phone, on a message thread, and by email, as well as being available to the team after hours and weekends. Staff stated the Nurse is in the community nearly all day, coordinating medical hospitalizations, as seen in records reviewed, as well as attending program meetings remotely, often offering education on medication side effects to the team. Two members interviewed reported that the Nurse comes to their home monthly to administer injections or to deliver medications. The Nurse is responsible for coordinating medication needs of all members on the team. Staff interviewed state the team will	• Hire two full time Nurses to serve the 91 members of the team. • Evaluate responsibilities of the position in an effort to gain understanding of barriers to retain trained and qualified staff. Consider technical assistance in this area.

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			first triage cases with the Nurse before escalating to the Psychiatrist. One member interviewed expressed particular frustration and disappointment in the high turnover of the Nurse positions on the team.	
H9	Substance Abuse Specialist on Team	1 – 5 1	The team has an intern providing substance abuse treatment services 20 hours a week equating to 27% FTE. There are 64 members with a co-occurring diagnosis. The SAS is enrolled in a Master of Science in Professional Counseling program at a local university. The SAS does not have a year or more of experience/training in delivering substance use treatment services to individuals with an SMI. Training records provided show one 3 credit course in addictions and substance use disorders completed three years ago.	• Fill the vacant SAS positions. The team should have 2 FTE SASs. When screening potential candidates for the position, consider experience working with members with a co-occurring disorder, and integrated care. The SAS should have the capability to cross train other ACT specialists in this area. • Ensure staff providing substance use treatment services receive necessary training and regular supervision in an evidence-based integrated substance use treatment approach.
H10	Vocational Specialist on Team	1 – 5 1	The team has an Employment Specialist (ES) that joined the team in February 2021. Records provided showed the ES participated in three hours of training in delivering vocational services. The ES does not have a year of experience providing vocational rehabilitation services or supporting adults with a serious mental illness (SMI) find and maintain employment in integrated settings.	• Fill the vacant vocational specialist position. The importance of helping members find employment and meaningful activities cannot be emphasized enough. Employment provides a sense of identity, gives a sense of purpose, and provides structure to one's day. Work can build natural supports and self-confidence. • Ensure vocational staff receive regular training, guidance, and supervision related to vocational supports, best practices, and strategies to engage members to pursue and obtain competitive positions. Participating in meetings with other Vocational Specialist (VS) staff within the agency may aid them by sharing job leads or strategies based on their job

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				development activities. Investigate opportunities in the system of care where those collaborative meetings may be occurring. Create regular training opportunities for VSs to receive education on best practices for members.
H11	Program Size	1 – 5 4	The team has eight staff assigned: Psychiatrist, CC, Nurse, SAS (intern), Employment Specialist, Housing Specialist, Peer Support Specialist, and an ACT Specialist. *This item is not adjusted for the size of the client roster.*	• Hire and maintain adequate staffing. A fully staffed team allows the team to consistently provide diverse coverage; allows staff to practice their specialties which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member.
O1	Explicit Admission Criteria	1 – 5 5	Based on interviews with staff, the team follows the *Mercy Care F-ACT Admission Criteria* and utilizes the *F-ACT Screening* tool to gather additional information on member history. The tool indicates the goal of F-ACT services are to decrease incarceration and hospitalizations through intense case management and support. Staff report referrals are generated by the RBHA (Regional Behavioral Health Authority) but are initiated by the Department of Corrections, county jails, probation, and by other ACT teams and providers. Staff reported that the CC conducts screenings of members referred. The CC, Clinical Lead and Psychiatrist will discuss each referral and a decision is made collaboratively whether a referral is appropriate.	
O2	Intake Rate	1 – 5 4	In the past six months referrals never exceeded six a month however, the team has lost considerable staff since December, with a high of five vacant positions in January. Two members were admitted	• Ideally, new intakes should not exceed six each month for a fully staffed team. When a team is already burdened because of vacant positions and turnover, reconsider

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			each in February and March, as well as in November. October four new members were admitted to the team. One new member was admitted in December and in January. One staff described a recently referred member diagnosed with a personality disorder as requiring a lot of interventions from an already burdened team.	admitting new members. Providing a full array of services to new members is difficult when a team is not staffed to capacity, nor has the training or experience of delivering ACT services.
O3	Full Responsibility for Treatment Services	1 – 5 4	Based on staff interviews the team provides psychiatric services, substance use treatment services, and employment and rehabilitative services. Staff interviewed described the team providing supports to the few members interested in seeking employment by discussing their dream job, getting assistance with job search, updating resumes, and completing online applications. In addition, the team offers support to the eight members currently employed. One member asked the team to assist with speaking with their supervisor in order to request accommodations. Staff interviewed reported that 12- 14 members reside where there is some level of staff on site, and that staff will coordinate care with the team. The team will provide medication monitoring to the members that require it, but some residences offer medication reminders and may hold medication. Several members on the team receive counseling/psychotherapy from providers off the team. At least one member is engaged in counseling with an agency therapist and three others are participating in specialized counseling off the team. The team does provide counseling to two members through the temporary staff that is also	• As able, work to assist members to locate independent housing in a less restrictive environment which can reduce the possibility for overlapping services with other treatment providers. • The F-ACT team should provide counseling/psychotherapy services to members.

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			providing substance use treatment services.	
O4	Responsibility for Crisis Services	1 – 5 5	Staff interviewed reported that the team provides 24-hour, seven day a week crisis services. Staff rotate on-call responsibilities every day, including the CC. Staff report there is no back up but that they have fifteen minutes to return a member's call, and will go out into the community. Some staff suggested the on-call number is used for general calls during the day, such as requesting transportation, or just wanting to talk. The on-call number is regularly provided to members and shared with probation officers, psychiatric intake staff, and others. All members interviewed were aware of the team availability and two reported to have used it in the past.	• Consider limiting on-call staff responsibilities by redefining on-call to be designated for emergencies after hours and weekends. Some teams have calls forwarded to the program assistant or other administrative staff during business hours to delineate crisis services from normal business day needs. • Ensure staff have access to clinical supervision when addressing member needs after hours.
O5	Responsibility for Hospital Admissions	1 – 5 4	Review of the ten most recent psychiatric hospital admissions showed the team was directly involved in seven. Several members (4) were court ordered to treatment and those orders were amended by either the team or local law enforcement. Staff reported that the team will offer members an appointment with the Psychiatrist if they are requesting psychiatric hospitalization. Members will be provided transportation by the team and ensure inpatient staff have historical context and team contact information, as well as assistance in scheduling doctor-to-doctor and nurse to-nurse calls to help facilitate the discharge planning process. During the public health emergency, visits were not allowed by inpatient hospitals. Staff reported that recently, some hospitals have begun to allow inpatient visits with members by clinical team staff.	• Work with members and their support networks to discuss how the team can support them in the event of a psychiatric hospital admission, especially if members have a history of hospitalization without team support. • Increasing member engagement through a higher frequency of contact and intensity of services may offer staff more opportunities to assess and provide interventions to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build rapport with natural/informal supports.
O6	Responsibility for	1 – 5	Based on review with staff of the ten most recent	• Ensure hospital discharge protocols are

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	Hospital Discharge Planning	5	psychiatric hospital discharges, the team was directly involved in 80%. Staff reported discharge planning begins when members enter an inpatient psychiatric program and that they regularly coordinate with inpatient staff to prepare for the member to be discharged. Upon learning of the discharge date, the team receives paperwork form the inpatient facility, assists the member with transportation, obtaining medications, ensures they have food and basic necessities at their home/placement, and provided the member with an appointment for the Psychiatrist. The team will then follow up in-person for the next five days to provide additional support and transportation for appointments. However, in one record reviewed from a period before the public health emergency, the team did not document provision of five days of in-person follow up to a newly admitted member to the team.	adhered to and documented in member clinical records.
O7	Time-unlimited Services	1 – 5 4	Staff interviewed reported five members graduated from the team during the past 12 months. Member service plans reflect the transition from intensive services to a lower level of need, per staff report. It was estimated 7 – 10% of members, or more depending on their needs, will graduate from the team in the next year.	• Graduation rates on ACT teams should be less than 5% annually. (F)ACT services should be time-unlimited to support clients whose illness may have been of long duration or emerged prior to development of healthy relationships and coping skills.
S1	Community-based Services	1 – 5 4	Staff report that due to the public health emergency, some members remain fearful of allowing staff into their homes. Staff report that telehealth services are being provided to those members and educated all members on actions to take to minimize risk of contagion, including providing masks and sanitizer. Some members have obtained the vaccination and are now allowing home visits. Of members interviewed,	• Increase community contacts with members with consideration of their willingness. 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.

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			one reported being happy to allow any staff to visit their home but has had infrequent visits since the public health emergency. Another member reported seeing the staff from the team weekly when assisted with laundry and purchasing groceries. Yet another member reported seeing the team mostly at the clinic. A review of ten randomly selected member records, for a period before the public health emergency, showed a median of 74% of contacts staff had with members occurred in the community. Of the members that had contact from the team during that period, averages ranged from two members with 50% in the community, to four members with 100% of contacts in the community.	• Continue efforts to offer education and support on how members can take action to decrease the risk of contagion.
S2	No Drop-out Policy	1 – 5 4	Although not a fidelity measure, review of data with staff showed a large number of members from the team returned to incarceration (17). At least five members transferred to other ACT teams in the area and two were assisted with referrals when moving out of the area. One member died in the past year. One member moved out of the area without informing the team. At least eight members could not be located during the past year. One member interviewed expressed consideration of transferring to another team because of the high turnover on the team and low staffing.	• 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. • See recommendations for *S3: Assertive Engagement Mechanisms.*
S3	Assertive Engagement Mechanisms	1 – 5 3	Assertive outreach efforts were discussed for at least fifteen members during the program meeting observed. The *F-ACT Re-Engagement Policy* was provided to reviewers which includes four attempts a week, two in the community, and two by phone/electronic. Several members were	• Ensure the team is assisting members in working on their recovery goals as identified. By using Motivational Interviewing and other techniques, the team can assist members in identifying

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			multiple months into outreach without any contact from the team. One staff stated that difficult to engage members draw the team's time and attention away from others that are more willing to engage. One member record identified obtaining work and having their own place as goals, but the member was on outreach the entire month period reviewed. When the member did reach out by phone asking for in-person support, the team had law enforcement pick up the member on an amended court order. Staff unaware of the team's actions, completed outreach the following day. The member was not seen inpatient until at least two days later. The re-engagement policy states that members will be assessed for a lower level of care after four weeks of outreach.	meaningful recovery goals and offer the supports and services for members to reach those goals. Goals may change frequently for those members not engaged in recovery, but it is important for the team to adjust their services to meet the member's needs regardless. • Improve coordination and communication among the team to improve member experience and to maximize team effort to engage members.
S4	Intensity of Services	1 – 5 2	Per a review of ten randomly selected member records, during a month period prior to the public health emergency, the median amount of time the team spends in-person with members per week, is about 43 minutes. One member record showed in-person contact with the team once every seven days by the same staff person. *The fidelity tool does not accommodate for telehealth services.*	• Increase the intensity of services delivered to members. ACT services are designed to provide a specific combination of services for each member at the frequency and intensity to meet their needs. Focus on delivering community-based contacts that are individualized and work to support the member to achieve his or her unique recovery vision as identified in their service plan.
S5	Frequency of Contact	1 – 5 2	The median weekly in-person contact for ten members was 1.25, based on review of records for a one-month period before the public health emergency. Over a month timeframe, only one member received an average of four or more contacts per week. This particular member was participating in daily medication observations.	• Engage more frequently with members with a goal of averaging four or more contacts per week, per member across the team. Improved outcomes are associated with frequent contact. • When engaging members at a higher frequency, staff knowledge of member

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			The fidelity tool does not accommodate for telehealth services.	goals and steps toward progress becomes more important as staff assist in the next steps.
S6	Work with Support System	1 – 5 3	Staff interviewed estimated 5 – 50% of the team's 91 members have an informal natural support that the team has been in contact with (at least once) in any given month. Staff stated that of members with a natural support, the team has weekly contact, especially those members that live with their supports. One staff reported that the team regularly discusses interactions with natural supports during the program meeting. Per record review, for a period before the public health emergency, staff averaged 1.6 contacts per month for each member with a support system in the community. The highest number of contacts of the ten records reviewed was eight in a month period. One staff stated that some members do not include their supports in their treatment. Another staff reported that due to the public health emergency, family members are less involved as they do not attend appointments at the clinic with members as they have done in the past.	• Include members' supports as part of the treatment team and use those times as opportunities to provide education and assistance to those supports. Optimally, ACT staff has contact with informal supports an average of four times or more monthly as partners in supporting members' recovery goals. • Assist members to develop and identify their support systems. This is especially important when members first join the team as those supports may be the only contact when a member is disengaged in their care. Discuss with members the benefits of involving natural supports in their treatment. • Evaluate methods of tracking or monitoring staff documentation of contacts with natural supports.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Based on records provided, individual substance use treatment services are regularly offered and provided. Staff identified 64 members being diagnosed with a co-occurring disorder (COD) and reported that 20 meet with the SAS each month. Members vary in their number of sessions a month. About 10 members schedule every week for a set day and time, and may have an additional phone session for a check in. Others are less structured, meeting every other week. Sessions last from 15 – 30 minutes regularly, yet some may	• Increase the delivery of individualized substance use treatment services to members with a co-occurring diagnosis on the team to average 24 minutes or more a week across those members. • See recommendations for *H9: Substance Abuse Specialist on Team.*

Item #	Item	Rating	Rating Rationale	Recommendations
			be longer or shorter depending on what the member's needs are. The SAS attempts to meet with each of them at least once weekly. Resources drawn upon to guide treatment provided include *Dialectical Behavior Therapy (DBT) Skills Training: Handouts and Worksheets*, Marsha Linehan; *Co-Occurring Disorders Program: Cognitive Behavioral Therapy*, and *Integrated Services for Substance Use and Mental Health Problems, Hazelden.*	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Per staff report and records provided, less than 10% of members with a COD attended one group offered by the team in a month period before the review. Staff reported the use of DBT worksheets to support members having a clean and clear mind. The group is co-facilitated with an ACT SAS from another team.	• All F-ACT staff should encourage members with a co-occurring diagnosis to participate in treatment groups. Ideally, at least 50% of members diagnosed with a COD attend at least one treatment group monthly. • Co-occurring treatment groups work best when based in an evidence-based practice (EBP) – treatment model. Consider structuring groups around proven curriculum for optimal impact. • Consider offering 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 (Dual Disorders) Model	1 – 5 2	The team appears to be based in a traditional approach to substance use treatment. No staff discussed the use of an integrated model, the blending of both psychiatric and substance use treatment services for members, however, new employee training, identified in staff records provided, included courses relating to co-	• Provide all specialists with ongoing training and mentoring on a co-occurring disorders model. With high 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

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			occurring treatment. A lack of recovery-oriented language was noted in member records reviewed. One member record noted recommendations from the prescriber for sobriety but was not tied to specific outcomes. One staff interviewed supported the goal of abstinence as a goal for members. This team focuses on members being assessed for high risk to recidivate to incarceration. As identified earlier, a high rate of members had parole revoked during the previous 12 months. Abstinence may be part of members' conditions of release, and was noted in some service plans, but this was not reported to reviewers.	adheres to can promote continuity in the approach that F-ACT specialists use when supporting members in their recovery. • Regardless of members' conditions of probation/parole, the team should work to support members in their recovery goals. Train all staff in a stage-wise approach to treatment, including how specific interventions are directed to members depending on their stage of treatment. Staff can then optimize their interventions to match with the member's stage of change. Optimally, consistent evidence-based co-occurring treatment is provided.
S10	Role of Consumers on Treatment Team	1 – 5 5	Two staff interviewed reported there is at least one staff on the team with lived psychiatric recovery, yet another staff was unaware of anyone. None of the members interviewed were aware of any staff with lived psychiatric experience but were aware of other shared life experiences with staff.	• Ensure members and all staff are informed of a PSS, or other staff on the team with lived psychiatric experience. The PSS has specialized training and provide a valuable service to members, member's families, and bring a unique perspective to the clinical team. PSSs provide expertise about symptom management and the recovery process; promote a team culture that supports member choice and self-determination; provide peer counseling to members and families; share their story of recovery and practical experience; and carry out other rehabilitation and support functions of the team.
Total Score:		**93**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	4
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	4
8. Nurse on Team	1-5	2
9. Substance Abuse Specialist on Team	1-5	1
10. Vocational Specialist on Team	1-5	1
11. Program Size	1-5	4
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	4
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. 5Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
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	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.32**	
Highest Possible Score	**5**	