ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: March 11, 2021

To: Robert Rodgers, Clinical Coordinator
Doris Vaught, CEO

From: Annette Robertson, LMSW
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AHCCCS Fidelity Reviewers

Method

On February 8 – 9, 2021, Annette Robertson and Kerry Bastian completed a review of the Lifewell Behavioral Wellness South Mountain 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 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. Lifewell's services include integrated health care, outpatient counseling, psychosocial rehabilitation, residential care, multiple housing options, and clinics serving persons diagnosed with a serious mental illness.

Due to the COVID-19 public health emergency, it was determined that the record portion of the review should be documentation for a period prior to the public health emergency. Reference in this report to the member records reviewed and related documentation are for the period prior to the public health emergency. Due to the public health emergency, the review was conducted remotely, using video or phone contact to interview staff and members. Federal, State, and local government guidance regarding contact with others outside individuals' homes has varied per the positivity rates. Some agencies impose their own guidance which may be more restrictive relating to contact with others.

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.

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

- Observation of a daily ACT team meeting via videoconference.
- Individual interview with the Clinical Coordinator (CC).
- Individual interviews with the Substance Abuse, Housing, and Rehabilitation Specialists.

- Individual phone interviews with three members participating in ACT services with the team.
- Charts were reviewed for 10 members using the agency's electronic medical records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; ACT South Mountain brochure; calendars for 98 members; resumes and training records for the CC, Substance Abuse Specialist (SAS), and Vocational Specialist staff; and documentation of CC productivity.

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

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team is fully staffed with medical personnel: one Psychiatrist and two Nurses are assigned to the team.
- During the past six months, the team was able to maintain a low admission rate.
- The team is adequately staffed with ten full time employees delivering services to members.
- At least one staff on the team has lived experience of psychiatric recovery and uses self-disclosure when appropriate with members.

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

- The team experienced a turnover rate of 88% during the past two years. The position with the highest turnover was the Substance Abuse Specialist (SAS). Identify and find solutions to factors resulting in high turnover.
- The team has one SAS to provide individual and group services to 63 members with a substance use diagnosis and would benefit from an increased understanding of evidence-based practices to treat those with a dual diagnosis. Hire a second SAS with experience providing services to members with a Serious Mental Illness (SMI). Provide supervision by a clinician with experience delivering services to dually diagnosed members. The team should agree on an evidence-based practice co-occurring disorders treatment model to build knowledge within the team and to be consistent across specialists when engaging members in recovery. All team members should be engaging members with a dual diagnosis to participate in substance use treatment services.
- Improve involvement when members are seeking psychiatric hospital admission. The team should identify a general process to follow when members are seeking hospitalization. For members that frequently seek hospitalization without team support, educate them and their supports about how the team can assist. For high-risk members, develop plans to support members to remain in their community.
- Educate members on the benefits of involving natural supports in their treatment, and support members in identifying and building those supports. Developing and maintaining community/natural support enhances members' integration, functioning and reaching recovery. Ensure ACT specialists are documenting contacts with natural supports in member records.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, there were nine full-time equivalent (FTE) staff on the team, excluding the Psychiatrist and program assistant. It was reported that there are 97 members on the team, leaving a member to staff ratio of approximately 11:1.	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff. The entire caseload should be shared across ACT team members, a measure to reduce the burden on staff when supporting high needs clients, as well as ensuring clients are provided adequate intensity, diversity of staff, and individualization of services.
H2	Team Approach	1 – 5 5	Staff report using a team approach to delivering services to members and that nearly all members are seen by more than one staff person each week. Staff report they are assigned a caseload, 10 – 12 members each, but for paperwork purposes only. Staff interviewed reported to seeing 30 – 65 members a week. The higher end of the range referring to when staff are assigned to complete medication observations with members. Staff reported to considering member needs regarding in person or phone contact relating to the public health emergency, i.e., medically vulnerable. Staff reported wearing masks, requesting that members wear masks, meeting outdoors, and social distancing if meeting indoors. Records reviewed for a period prior to the public health emergency show 90% of members received an in person contact with more than one staff in a two-week period. Most members interviewed reported seeing four members in the week prior to the review, however, one reported not seeing anyone	• Continue efforts to ensure all members on the ACT roster have face-to-face contact with more than one staff in two weeks; a diversity of staff allows members access to unique perspectives and the expertise of staff.

			from the team unless attending an appointment at the clinic once a month.	
H3	Program Meeting	1 – 5 5	Staff interviews indicated the team meets five days a week via a web-based video conferencing tool, and the Psychiatrist attends all meetings in person. The Nurses attend on days they are scheduled to work unless attending to member's needs. No Nurses were present at the meeting observed by reviewers. All members were reviewed, and staff reported the order is reversed every other day.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated delivering in person services to members 20 - 30% of the time and an additional 20% via phone. During the morning meeting observed, the CC described contact with several members the week prior. Data provided reviewers showed less than 10% of the CC's time in direct care with members from the team. *The fidelity tool does not accommodate for telehealth services.*	• Optimally, the CC should provide in person services to members 50% or more of the time. Shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery are appropriate activities. • Explore potential barriers to the CC providing direct services to members. Identify administrative functions that could be transferred to administrative staff or other team members.
H5	Continuity of Staffing	1 – 5 1	Based on information provided, the team experienced a turnover rate of 88% during the past two years. At least 21 staff left the team during this period. The position with the highest turnover was the SAS, with six staff leaving. An additional staff was in the SAS position for a brief period before moving to another position on the team and then eventually leaving the team.	• Examine employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention. 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. Some teams find offering more flexible scheduling such as 4 - 10-hour days, an incentive.

				• Ensure candidates being considered to fill vacant positions are prepared to deliver ACT level services, particularly for those candidates without prior experience working in the ACT model. • Ensure specialists are offered training and support in their specialty area. Being supported to provide services to members in the staff's specialty area may bring more value to their work and to the team.
H6	Staff Capacity	1 – 5 4	Based on information provided and reviewed with staff, the team had an 83% staffing capacity for the twelve months prior to the review. The team had eight months without a second SAS and seven months without staff in the Peer Support Specialist (PSS) position, a vital role on any ACT team.	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible. Filling vacant positions as soon as possible helps to reduce the potential burden on staff.
H7	Psychiatrist on Team	1 – 5 5	The team has one full-time Psychiatrist that works Monday – Friday. The Psychiatrist attends morning meetings daily, offering feedback on behaviors associated with specific diagnosis and how medications impact the symptoms. The psychiatrist sees members in-person at the clinic as well as telephonically for members uncomfortable coming to the clinic. Staff reported that the Psychiatrist does not conduct telehealth through video. Staff report the Psychiatrist is easily accessible in person and by phone. Members interviewed reported seeing the Psychiatrist monthly, or more often, and appreciate in person appointments. One member said they did not care for telephone appointments but understood the necessity.	• Support members concerned about coming into the clinic because of the public health emergency by use of telehealth services with video to offer an enhanced experience. Technology support may be necessary to support members and staff to ensure the experience is successful. If viewed as a failure, it may validate their decision to not participate.
H8	Nurse on Team	1 – 5 5	The team has two full-time nurses assigned. Staff described the Nurses as being accessible at the office, by phone, and text. Responsibilities	

			reportedly have recently changed to include one assigned day a week in the community to meet with members. Other duties include taking vitals, addressing medical concerns, health risk assessments, coordinating with primary care physicians, injections, and medication management. Staff reported that Nurses are assigned a caseload but are not responsible for completing updates to members' annual assessments or service plans.	
H9	Substance Abuse Specialist on Team	1 – 5 2	The team has one SAS assigned to work with 63 members diagnosed with a co-occurring disorder. The SAS has been with the team less than six months and does not have prior experience providing individual or group substance use treatment services. The SAS does have experience working with individuals with a Serious Mental Illness (SMI). Training records provided to reviewers showed several hours of training in IDDT and motivational interviewing. During the meeting observed the SAS reported on members and actions taken to engage in substance use treatment services. Member calendars showed the SAS providing community outreach to a member without a co-occurring diagnosis (COD). The CC provides substance use treatment services to one member of the team. The CC has more than one-year prior experience on an ACT team providing substance use treatment services.	• Support the SAS to concentrate on practicing their specialty. Consider removing responsibilities from the SAS's workload, i.e., on-call responsibilities, outreach to members without a COD, to support focus on engaging members and providing substance use treatment services while the team is understaffed in this area. • Hire a second SAS. Prioritize specific training and experience treating dually diagnosed adults using a co-occurring disorders model when hiring for the position. • Ensure the SAS(s) are provided with regular supervision (e.g., weekly) by an experienced substance use clinician that is knowledgeable about the co-occurring model and its relationship to the evidence-based practice of ACT. Empower the SASs as they cross-train the ACT team.
H10	Vocational Specialist on Team	1 – 5 4	The ACT team has two Vocational Staff (VS) staff; one identified as an Employment Specialist (ES) and the other as a Rehabilitation Specialist (RS). Both VS staff have several years history working with members with an SMI. The ES has been in the	• Provide training and support to the ES in helping clients to find and keep jobs in integrated work settings. Optimally, training would include strategies for

			role on the ACT team about six months and does not have prior experience assisting members find and keep employment in integrated settings. One member interviewed reported talking to the ES about their employment options. The RS has been in the role nearly a year and has prior ACT team experience. The ES and RS training records were submitted to reviewers and both have attended a training on the values of rehabilitation and employment in recent years.	engaging clients to consider employment, job development, supporting individualized job search, and providing follow-along support. • The entire ACT team may benefit from training and education on the principles of the evidence-based practice of *Supported Employment*. Work in integrated settings is recognized as an essential part of recovery that supports positive outcomes such as higher self-esteem, better control of psychiatric symptoms, and life satisfaction attained through participation in society.
H11	Program Size	1 – 5 5	The ACT team has ten staff and is adequately staffed to serve the 97 members assigned to the team. Two positions were open at the time of the review, including the ACT Specialist and the second SAS position.	
O1	Explicit Admission Criteria	1 – 5 5	Based on interviews with staff, the team follows the Mercy Care ACT admission criteria. Staff reported that the CC and several Specialists on the team conduct screenings of members referred. Due to the public health emergency, staff are unable to conduct screenings in person when members are hospitalized, but report completing the screening over the phone. No screenings are conducted through telehealth (video) due to limitations with inpatient providers access to telehealth platforms. After the screening is completed, it is reviewed, along with member records by the CC and Psychiatrist for final determination.	
O2	Intake Rate	1 – 5 5	Per data provided and reviewed with the CC, 12 members were admitted to the team in the six months prior to the review. This rate of admissions	

			is appropriate, as there were never more than six new members admitted in a one month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric services, employment and rehabilitative services, most housing supports and substance abuse treatment. Regarding employment and rehabilitation supports, staff did indicate that in the past, referrals have been made to an outside vocational resource, i.e., Work Adjustment Training; however, at the time of the review there were no members enrolled. Housing services are provided mostly by the ACT team. Records reviewed for a period prior to the public health emergency showed some member's housing goals were not reflected in their service plan, nor was there documentation of coordination of care within the team or between agencies (residential treatment provider) regarding members' housing goals. The team offers opportunities for both group and individual substance use treatment services to members, but the team is understaffed in the position which does limit their ability to provide adequate services. Staff reported that four – five members receive substance use treatment services outside the team from an agency provider. The team does not provide counseling services to members of the team. Staff reported members are referred to an agency provider that also provides some substance use treatment services.	• Ensure all staff receive training in their specialized positions. ACT services should be fully integrated into a single team, with referrals to external providers only for specialty cases, such as court ordered services. • Explore options for providing counseling services within the team, either with new or currently existing ACT staff.
O4	Responsibility for Crisis Services	1 – 5 5	Per interviews with staff, the team provides 24-hour seven days a week on site crisis services in the community to members of the team. One staff stated the team tries to de-escalate the crisis over	• The ACT team should have access to psychiatric support by the team Psychiatrist or Nurse to address member needs when responding to urgent psychiatric crises.

			the phone but do often go into the community to support the member. Staff rotate on-call phone responsibilities weekly. Members are given a brochure with staff roles and phone numbers, and the on-call number listed. Of members interviewed, one was unsure of the on-call number, but another reported using the service in the past. Staff reported that neither the Psychiatrist nor Nurses are available after hours to support the on-call staff. Staff interviewed reported contacting the CC as back-up.	
O5	Responsibility for Hospital Admissions	1 – 5 2	Per review with staff of the ten most recent psychiatric hospital admissions, the team directly supported 30% of members. The team reports that when members express a desire to be psychiatrically hospitalized, they will assess their needs and offer additional supports, as well as an appointment with the Psychiatrist in an effort to divert them from hospitalization, trying to support them in the environment they are in. Another staff said that if members want to be admitted, they will arrange a taxi, supporting the member's right to make decisions regarding their own treatment. Yet another staff said a team member would transport the member to the psychiatric unit, provide a medication log to inpatient staff, and sit with them member through the admission process. Of the psychiatric hospital admissions the team was directly involved, all were members court ordered to participate in psychiatric services and whose orders were amended by the team. One staff reported the high self-admission rate was likely tied to lack of members having or encouraged to use the team's on-call number as	• ACT teams should, ideally, be directly supporting 90% of members' psychiatric hospital admissions. Continue efforts to engage with members expressing an increase of symptoms and providing them with additional support in their environment. • The team should identify a general process to follow when members are seeking hospitalization, bringing cohesion to the team approach. • For members that tend to self-admit to psychiatric hospitals, ensure they, and their natural supports are aware of on-call and team availability to support when in crisis. Some teams offer to program the on-call number into members' and natural support's phones to improve involvement. • Improve planning and coordination for high-risk members by the team. Consider developing prevention plans identifying interventions provided by the team to support members to remain in their community. Doing so could assist in

			well as less reliance on the team during the public health emergency.	allowing these members to remain in the community.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Of the ten most recent psychiatric hospital discharges, it appears the team was involved in 80%. Staff interviewed report that once members are admitted, the team begins discussing the discharge plan, coordinating with the inpatient team several times a week, arranging doctor to doctor calls, and engaging members' natural supports. Staff report these responsibilities may rotate day to day depending on the complexity of the case. Upon discharge, staff will obtain discharge paperwork when picking up members to transport to their home, provide follow up appointments for the Psychiatrist and Nurse, and ensure the member has food and medications. The team will provide five days of in person or by phone contact with the member, encouraging them to stay engaged with the team. Records reviewed, from a period prior to the public health emergency, showed a member with a high-risk medical procedure not receiving five day follow up from the team or coordination of medical needs. Additionally, member calendars provided failed to demonstrate follow through of the five day follow up process for another member. One staff reported coordination of care	• Provide continuity of care to members of the ACT team after discharge from psychiatric hospitalization by following the activities listed by staff, including integrated care coordination. • Consider developing a consistent process of coordinating member care while inpatient. Some teams have the Nurses complete coordination of care, while others may designate the assigned ACT Specialist.

			has been impacted by the public health emergency, but the team is persistent.	
O7	Time-unlimited Services	1 – 5 5	Staff interviewed reported that the team does not expect to graduate any more than 5% of members during the next 12 months, stating that a couple members are getting ready to graduate. One member calendar provided to reviewers identified a plan to step the member down to a lower level of care.	
S1	Community-based Services	1 – 5 3	Per review of records prior to the public health emergency, the team provided 58% of services to members in the community. Records reviewed showed one member had nearly 20 contacts during the month period reviewed, but only one contact at their residence, the rest were at the office. Three members received 85% or more of services in the community. During the program meeting observed, most staff discussed plans to meet members in the community. Staff interviewed reported that 80 – 90% of services delivered to members is done in the community, however, this rate of delivery differs across the team. Some staff depend on phone contact as their main source of contact with members which may be related to the public health emergency. One member interviewed reported the team does not come to their home. Other members reported to have visits by the team at their home, noting staff taking precautions to follow public health guidance.	• Optimally, ACT teams provide 80% of services to members in the community, a more natural setting than the clinic. • To the extent possible during the public health emergency, ensure members receive contact from the team in the manner with which they are most comfortable. Some members may prefer in-person visits at a lesser rate but may want a higher rate of phone contact. To reduce potential burden on staff delivering community services, ensure these responsibilities are distributed amongst the team.
S2	No Drop-out Policy	1 – 5 4	Data provided was reviewed with staff and it appears the team has an 8% drop out rate from ACT services. Data provided indicates no members refused services in the past 12 months, nor were there any that left the area without a referral for	• 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, informal/natural support involvement,

			services. Seven members were listed as being unable to be located by the team. Three members moved from the area and were assisted by the team to receive services in their new location. One member graduated from ACT services, while 10 - 11 members returned to the Supportive level of care, likely due to obtaining residential treatment services. Five members working with the team died during the past year.	assertive engagement practices, and taking a recovery perspective with client care.
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff interviewed report utilizing an 8-week outreach process. The primary specialist assigned has responsibility for conducting and reporting on the outreach efforts in the program meeting. Staff indicated that the team makes four attempts a week, two by phone, and two in the community to locate members disengaged from the team. Barriers to keeping members engaged were reported to be no telephone, no family support, lack of housing, substance use, and inconsistency in taking prescribed medications. Staff stated that some members find the intensity of ACT services intrusive and step away from the team. During the meeting observed, staff updated the team on efforts to engage with a few members but plans lacked urgency and did not include coordination with natural supports. One record reviewed showed a member on outreach however, the team had no contact with the member's natural supports where weeks later the member was located.	• If members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Include natural supports, present and past, when conduction outreach. • Ensure a diversity of staff are utilized to engage members disengaged from the team. Leadership may want to consider assigning outreach responsibilities during the program meeting to make certain members are exposed to all specialists on the team, and to reduce potential burden on staff more willing to provide outreach in the community.
S4	Intensity of Services	1 – 5 3	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 spent in-person with members per week, is about 57 minutes. The member with the highest	• Continue efforts to increase intensity of services providing an average of two hours or more of face-to-face services per week to help members with serious symptoms maintain and improve their functioning in

			average of minutes served, 172, appeared to be residing in ACT housing. Three members received an average of 120 minutes or more service a week for the period reviewed: one regularly attended groups at the clinic and one other was receiving medication observation services. Some staff interviewed reported an imbalance in delivery of in person versus phone contact with members within the team partly, but not entirely, due to the public health emergency.	the community. ACT services were designed to provide a specific combination of services for each member at a frequency and intensity to meet their needs. Focus on delivering community-based contacts that are individualized and geared toward building skills that help the member achieve to his or her unique recovery vision. • Leadership may want to consider meeting with the ACT team to discuss barriers to high service intensity. This may include an assessment of available technology, and staff schedules and workloads.
S5	Frequency of Contact	1 – 5 3	The median number of weekly in-person contact for ten members was just under 2.38, based on review of records during a period prior to the public health emergency. Over a month timeframe, three of ten members received an average of four or more contacts per week. One staff reported that members are no longer scheduled to see a Nurse on the same day as the Psychiatrist per direction from leadership. Further, members often do not return the following day to see the other provider, resulting in missed injections and irregularly filled prescriptions. It was unclear when this directive was given to the team. During the observed morning meeting, staff reported on attempts and plans to see members in the community. One staff interviewed stated that frequency of contact with members is tracked during the program meeting and that was indicated on member calendars sent to reviewers.	• Continue efforts to increase the frequency of contact with members by ACT staff, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support member goals. • Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to provide ongoing support. Improved outcomes are associated with frequent contact. All staff of the ACT team should be invested in delivering a high frequency of contact to members.
S6	Work with Support System	1 – 5	Staff interviewed estimated that 50 – 80 of the team's 97 members have an informal support.	• Educate members on the benefits of natural supports, and support members in

		1	Staff stated that the team has contact with 20 – 25 natural supports in any given month. Of the ten randomly selected member records, staff had contact with members' informal supports an average of 0.30 times a month. Staff infrequently referenced recent contact with informal supports during the morning meeting observed. Of the members interviewed, two reported not wanting family involved with their treatment with the ACT team, a third reported wanting the team to involve family that had previously been involved in their care while at another clinic.	identifying and building those supports. Developing and maintaining community/natural support enhances members' integration, functioning and reaching recovery. • With member permission, include natural supports as part of the treatment team, and use those times as opportunities to provide education and assistance to supports as well. • Evaluate methods of tracking or monitoring staff documentation of contacts with natural supports, i.e., review documentation during the program meeting one day a week or consider peer review methods.
S7	Individualized Substance Abuse Treatment	1 – 5 3	The team provides some structured individualized substance use treatment services to a handful of the 63 members with a co-occurring disorder on the team. The SAS reported meeting with six members weekly at the clinic for individual sessions, stating none are comfortable with video conferencing but will occasionally participate in substance use treatment sessions by phone. A sampling of member calendars with a COD reviewed and a personal calendar provided by the SAS, identified dates of telephone or in-person contact provided by the SAS. The CC also reports delivering individual substance use treatment services to at least one member and conducts those sessions at the member's home following public safety guidelines. Staff interviewed, who provide substance use treatment services, were unsure of the number of members to whom the other was providing individualized substance use	• Engage members with a substance use diagnosis to participate in regularly occurring individual substance use treatment with ACT staff. Across all members with a co-occurring diagnosis, an average of 24 minutes or more of formal structured individual substance use treatment should be provided weekly. • Provide the SAS the necessary training, mentoring, and ongoing guidance to provide structured, individual substance use counseling to members identified with a co-occurring disorder. Ideally, the SAS would receive weekly supervision by an experienced substance use clinician that is knowledgeable about the co-occurring model and its relationship to the evidence-based practice of ACT.

			treatment services. Staff interviewed reported some members are receiving individual substance use treatment services off the team from a counselor with the agency, a prior SAS on the team. Staff were unsure of the exact number of members receiving that service. Member records reviewed prior to the public health emergency showed the previous SAS delivering individual substance abuse treatment services in member homes.	• Continue efforts to recruit and hire an additional SAS for the ACT program that has experience working with individuals with an SMI.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff reported that about 10% of members with a co-occurring disorder are attending an in-person substance use treatment group provided by the SAS. Due to the public health emergency, the clinic has a cap on how many members can be in the office, so the group attendance is limited to 10 members. Staff interviewed reported plans to provide a second group on another day of the week once they hit full capacity of the group. One staff stated the team had offered a telehealth substance use treatment group but was unsuccessful in delivering it to members. Another staff stated members lacked skills and knowledge using telehealth platforms. When asked about curriculum utilized, staff reported use of the *Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders*. Another staff interviewed stated the stage wise approach was used in the group treatment and was unaware of any manual utilized.	• All ACT staff should encourage members diagnosed with a co-occurring diagnosis to participate in treatment groups based on their stage of change. Optimally, 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. • 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. • Provide support to members in gaining competency in using telehealth platforms to allow them a variety of service delivery options.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Based on records reviewed and staff interviews the team appears to use a combination of traditional and *stage wise treatment* approaches	• Provide all specialists with ongoing training and mentoring on a co-occurring disorders model, such as IDDT, and in the principles

			to COD treatment. In general, staff demonstrated understanding of the *stages of change* model, but staff interviewed were not able to describe effective interventions that align with each change stage. One staff expressed doubt in the value of the use of the stage wise approach. During the meeting observed, staff identified members' assessed stage of change and these were also noted on the member calendars provided to reviewers. Staff interviewed did not identify abstinence as a goal, rather supporting reduction of use as the standard and were able to offer a recent example of how the team supported a member in that approach. One staff interviewed reported being unfamiliar with harm reduction prior to working on the team, however; stated the team has been helpful by encouraging the replacement of traditional terminology with recovery orientated language.	of *Motivational Interviewing*. 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 adheres to can promote continuity in the approach that ACT specialists use when supporting members in their recovery. • Train all staff in a stage-wise approach to treatment, including how specific interventions are directed to members depending on their stage of treatment. Training staff in a comprehensive stage-wise treatment model may help the team to maintain consistent service if SASs transition off the team as well as experience success, rather than frustration, when engaging with members. Ideally, consistent evidence-based co-occurring treatment is provided and supported by the entire team. • One of the main characteristics of the EBP of ACT is that the member is receiving treatment for their mental illness and their substance use disorder from the same team. Coordinate transitions for members receiving treatment from providers off the team to substance use treatment by the ACT team.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team employs a full-time, fully integrated Peer Support Specialist (PSS). Staff interviewed stated that although the PSS is new to the role, when appropriate, they will share their personal story of psychiatric recovery with members, and that	

			members really seem to identify with the PSS. Staff reported the PSS offers insight to the team on services that were helpful to them in their recovery and does well with coordinating member services. Although most members interviewed were not aware of a staff on the team with psychiatric lived experience, members expressed appreciation for the role and found it supportive in the past.	
Total Score:		102		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	5
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	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	2
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	5

5. Responsibility for Hospital Admissions	1-5	2
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	3
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	3.64	
Highest Possible Score	**5**	