**ASSERTIVE COMMUNITY TREATMENT (ACT)**
**FIDELITY REPORT**

Date: September 26, 2024

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## Introduction

Arizona Health Care Cost Containment System has contracted with the 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 August 26 – 28, 2024, Fidelity Reviewers completed a review of the Copa Health Gateway 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.

Copa Health operates several outpatient behavioral health clinics and multiple ACT teams, providing a range of services including integrated health care, employment-related assistance, day program activities, and residential services. The individuals served through the agency are referred to as *clients*, *members*, and *patients*, but for 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 observe meetings, and to interview staff and members.

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

- Remote observation of an ACT team program meeting on August 27, 2024.

- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with the Employment, Rehabilitation, and Peer Support Specialists, as well as the Psychiatric Nurse Practitioner who provides psychotherapy/counseling to some members of the team.
- Individual phone interview with the Co-Occurring Disorders Specialist.
- Individual phone interviews with three members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, ACT Program Manager, and representatives from the local contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system. The sample includes members from the following health plans: RBHA and DDD.
- Review of documents: *Mercy Care ACT Admission Criteria*; *8 Week Outreach Workflow*; member calendars; copies of cover pages of substance use disorder treatment and training materials utilized; ACT *Team Contact List*; ACT-Exit-Criteria-Screening-Tool, Gateway ACT Brochure; resumes and training records for the Vocational and Co-Occurring Disorders Specialist staff; and the *Clinical Coordinator productivity report* for a month period before the review.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a 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 with little room for improvement*).

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 services to 99 members. The team has an appropriate member to staff ratio of 10:1.
- The team, including the Psychiatric Nurse Practitioner, meets four days a week to discuss members. During the meeting observed, multiple staff contributed to the discussion by reporting on recent and planned contacts with members.
- The team has a fully dedicated Psychiatric Nurse Practitioner who is highly involved in member care, readily available to the team, and provides services to members and their natural supports in the community. Unique to this team, the Psychiatric Nurse Practitioner also provides therapeutic counseling to members and their families.
- The team is available to provide crisis support to members 24 hours a day, seven days a week by phone and in the community.
- Despite the high turnover of staff, the team has been able to retain 100% of members on the team.
- Members have access to at least one staff person with lived or living psychiatric experience on the team who shares their experiences with members.

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

- The team experienced a staff turnover rate of 79% during the past two years. Identify factors that contributed to staff turnover and implement a protocol that supports retention.
- Increase service delivery to members in their communities. ACT services are most effective when delivered in the community where challenges are likely to arise. This setting allows staff to directly assess member needs, monitor progress, model behaviors, and assist members in using resources. Services should be provided in a natural, non-clinical setting at least 80% of the time.
- Continue efforts to increase contacts with natural supports to an average of four (4) per month for each member with a support system. Ensure documentation of all natural support contacts are included in members' clinical records.
- Members are not provided group treatment for co-occurring disorders. Follow through with plans to offer group treatment from team staff. Ideally, 50% or more of members with co-occurring disorders attend at least one group per month. The entire ACT team is responsible for engaging members in substance use treatment services.
- Provide ongoing training and clinical oversight to the team pertaining to a co-occurring disorders treatment model. The team would benefit from an improved understanding of the co-occurring disorders treatment model which may help achieve maximum opportunity to support members in recovery and symptom management.

**ACT FIDELITY SCALE**

| Item # | Item | Rating | Rating Rationale | Recommendations |
|---|---|---|---|---|
| H1 | Small Caseload | 1 – 5<br><br>5 | The ACT team serves 99 members with 10 full-time equivalent (FTE) direct service staff, excluding the Psychiatric Nurse Practitioner and administrative staff. The member to staff ratio is approximately 10:1.<br><br>Staff on the team include the Clinical Coordinator, Employment Specialist, Rehabilitation Specialist, Housing Specialist, Independent Living Specialist, ACT Specialist, Peer Support Specialist, two Nurses, and a Co-Occurring Disorders Specialist. | |
| H2 | Team Approach | 1 - 5<br><br>4 | Staff estimate that 97% of members are seen by multiple staff within a two-week period. Each week, staff are assigned to one of seven zones that consists of 14 to 15 members residing in each zone. Staff are responsible for visiting members within these zones, but other team staff may assist at times. Staff reported seeing an average of six to eight members daily. Members interviewed estimated interacting with about four staff each week.<br><br>Of ten randomly selected member records reviewed, for a month period, a median of 80% of members received in-person contact from more than one staff from the team in a two-week period. | • Ideally, 90% of ACT members have in-person contact with more than one staff in a two-week period. Continue efforts to ensure all members on the ACT roster have in-person contact with more than one staff every two weeks; a diversity of staff allows members access to unique perspectives and expertise of staff. |
| H3 | Program Meeting | 1 - 5<br><br>5 | The team meets in-person four times a week to review all members on the roster. In addition, there is a weekly modified meeting to discuss | |

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| | | | the services of members with higher levels of need. The Psychiatric Nurse Practitioner and Nurses attend these meetings on their scheduled workdays.<br><br>During the observed program meeting, the Clinical Coordinator led the discussion, and all staff participated by providing updates on collaborative efforts regarding member needs. Topics included member appointments, recent and planned contacts for the week, updates on inpatient members, stages of change for members with co-occurring disorders, housing, employment, therapy engagement, ACT group participation, and natural support contact. | |
| H4 | Practicing ACT Leader | 1 - 5<br><br>3 | The Clinical Coordinator estimated providing in-person services to members four to five hours daily, both at the clinic and in the community.<br><br>A review of a productivity report of a recent 30-day period indicated that the Clinical Coordinator delivered direct services at 17% of the expected productivity level of other ACT staff. Members interviewed reported recent meetings with the Clinical Coordinator. Out of ten member records reviewed, there were four instances of the Clinical Coordinator delivering in-person services to three members. Documented activities included a hospital visit, responding to a crisis call at a member's residence, and providing services at the clinic. Three telephone contacts were documented in member records. | • Continue efforts to provide in-person services to members. Optimally, the ACT Clinical Coordinator delivers direct services to members accounting for at least 50% of the expected productivity of other ACT staff. |

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| | | | *The fidelity tool does not accommodate delivery of telehealth services. This item is dependent on the Provider productivity expectation.* | |
| H5 | Continuity of Staffing | 1 - 5<br>2 | Based on information provided, and reviewed with staff, 19 staff left the team with a turnover rate of 79% during the past two years. Essentially, all positions on the team experienced a turnover of staff in the past two years. Interviewed members voiced concerns about the team's staff turnover, while one member expressed appreciation for the "new team." | • If not done so already, attempt to identify factors that contributed to staff turnover or that support retention. Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their supports, as well as reducing potential burden on staff.<br>• Support specialty staff to work in their area of interest and expertise with members. Research shows staff remain in positions longer when supported in their roles by being provided supervision and training in their specialty practice. |
| H6 | Staff Capacity | 1 - 5<br>3 | In the past 12 months, the team operated at approximately 74% of full staffing capacity. The positions with the highest vacancy rates were the Employment Specialist and Co-Occurring Disorders Specialist. | • Continue efforts to screen potential hires for the responsibilities of ACT services with the goal of operating at 95% or more of full staffing annually. |
| H7 | Psychiatrist on Team | 1 - 5<br>5 | The team includes one full-time equivalent (FTE) Psychiatric Nurse Practitioner (Prescriber), who is scheduled to work four, ten-hour days but has a flexible schedule to accommodate members' needs which includes weekends. Staff reported that the Prescriber sees members in-person at the clinic two days a week, via videoconference one day a week, and in the community one day a week. The Prescriber is also available to the team after hours and on weekends. | |

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| | | | Of the ten records reviewed over a one-month period, it was noted that the Prescriber saw nine out of ten members, with four records indicating multiple interactions with the Prescriber through videoconference, in-person clinic visits, and community visits. Members interviewed reported meeting with the Prescriber at least once a month. | |
| H8 | Nurse on Team | 1 - 5<br><br>5 | The team has two Nurses that work exclusively with the ACT members and attend program meetings on their scheduled workdays. At the time of the review, one Nurse was on leave.<br><br>Staff reported the Nurses administer injections in the office and in the community, medical appointment coordination, coordinate psychiatric hospital admissions and discharges, symptom management, and provide case management services. Staff report that the Nurses are readily accessible to the team.<br><br>Per review of records, the Nurses provided direct in-person services at the clinic to eight members in the month period reviewed. Members interviewed reported meeting with a Nurse at least monthly. | |
| H9 | Co-Occurring Disorders Specialist on Team | 1 - 5<br><br>2 | The team includes one Co-Occurring Disorders Specialist who joined the team in May 2024. Training records indicate that this specialist has completed one hour of substance use-related training in the past two years. Although the specialist has worked with individuals with substance use disorders in previous roles, there is no evidence of direct experience providing | • ACT teams have two Co-Occurring Disorders Specialists (CODS) assigned to provide services to members. When screening potential candidates for the position, consider one year or more of experience working with members with co-occurring disorders and integrated care. |

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| | | | substance use treatment services. Clinical supervision is provided to all agency Co-Occurring Disorders Specialists every two weeks, though some staff could not confirm this. | • Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. On ACT teams, CODS have the capability to cross-train other staff, providing guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model utilized by the team.<br>• Make available ongoing supervision to the CODS to support efforts to provide individual and group substance use treatment services. |
| H10 | Vocational Specialist on Team | 1 - 5<br>2 | The team includes an Employment and a Rehabilitation Specialist. The specialists joined the team within the two months leading up to the review. Neither specialist has at least one year of experience in assisting individuals with serious mental illness in securing and maintaining competitive employment. The provided training records did not show evidence of training related to supporting individuals with serious mental illness in job acquisition and retention. | • Ensure both Vocational Specialist staff receive ongoing training in helping members find and retain competitive employment in integrated settings. Supervision by qualified staff should be provided to support skill development during the first year in the role when there is no prior experience. |
| H11 | Program Size | 1 - 5<br>5 | At the time of the review, the team was composed of 11 staff including the Psychiatric Nurse Practitioner. The team is of sufficient size to provide staffing diversity and coverage for members of the team. There was one vacant position: Co-Occurring Disorders Specialist. | |

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| O1 | Explicit Admission Criteria | 1 - 5<br><br>5 | Staff interviewed reported members are referred by the local contractor with a Regional Behavioral Health Agreement, hospitals, and lower level of care case management teams from within the agency. The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential members for admission. The Clinical Coordinator conducts most of the screenings by reviewing the referral packet and meeting with the prospective member. A doctor-to-doctor consultation is also completed. The final decision for admission to the team is made by the Prescriber and the Clinical Coordinator. The team reported that there is no pressure to admit members who may not be appropriate for ACT. | |
| O2 | Intake Rate | 1 - 5<br><br>5 | Per data provided, and reviewed with staff, the ACT team has an appropriate rate of admissions. The team accepted a total of eight new members over the previous six months, with no more than two admissions monthly. | |
| O3 | Full Responsibility for Treatment Services | 1 - 5<br><br>3 | In addition to case management, the team directly provides psychiatric services, and substance use treatment.<br><br>The team is not credited with the following services:<br><br>Housing Support - Based on staff interviews and data provided, the team has 23 members residing in settings where ACT services are duplicated.<br><br>Counseling/Psychotherapy - The Psychiatric Nurse Practitioner estimated providing therapy to approximately 20 members. Staff reported an | In the evidenced-based practice of ACT, all member services are delivered by the ACT team. As a transdisciplinary service delivery model, area specialists are trained and cross trained to provide the core components of ACT: case management, psychiatric services, counseling/psychotherapy, employment and rehabilitation services, housing support, and substance use treatment.<br>• Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff providing housing support. Enlist natural supports as a |

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| | | | additional 11 members receive this service by an agency counselor or from an outside provider.<br><br>Employment Support - Staff reported nine members on the team are competitively employed, approximately seven members are in job search activities supported by the team. Staff reported approximately six members are engaged in a work adjustment training programs or receiving employment support from a brokered provider. One member interviewed reported receiving services from a brokered provider utilizing a work adjustment training program. | resource to assist in identifying housing options.<br>• Transfer the delivery of counseling and therapeutic service provision of members from outside providers to the ACT team. Counseling/psychotherapy is made available to members on ACT teams and is provided by ACT staff. Ensure future staffing includes a person with qualifications to provide counseling/psychotherapy to members on the team.<br>• Ensure Vocational Specialist staff receive supervision and training to support directly assisting members to find and keep jobs in integrated work settings rather than relying on vendors. Educate all staff on the benefits of competitive employment versus other services (e.g., work adjustment training programs). |
| O4 | Responsibility for Crisis Services | 1 - 5<br><br>5 | Based on interviews, the ACT team is available to provide crisis services 24 hours a day, seven days a week. The on-call phone rotates between the specialist positions weekly. Members, natural supports, and inpatient teams are provided with the *ACT Team Contact List* that includes the on-call number, email for the Gateway ACT team, staff names and position titles, and phone numbers. Members interviewed were aware of the after-hours services available from the team.<br><br>When members reach out to the staff on-call and de-escalation has been attempted, when necessary, staff will respond in person within 15 | |

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| | | | minutes. Once on site, they assess the situation to determine the appropriate next steps. The Clinical Coordinator and Psychiatric Nurse Practitioner are available to support staff with coordination as needed. | |
| O5 | Responsibility for Hospital Admissions | 1 - 5<br><br>4 | Staff indicated that when a member is experiencing an increase of symptoms or requesting to be psychiatrically hospitalized, the team will go into the community to assess the member. Staff will coordinate with the Clinical Coordinator and the Psychiatric Nurse Practitioner, and the member will potentially be triaged by the Psychiatric Nurse Practitioner or Nurse. When the recommendation is for inpatient care, the team will transport the member, staying with them until admission, and will provide the inpatient team with information pertaining to the member and treatment team contact information.<br><br>The team reported being involved in 60% of the ten most recent psychiatric hospital admissions that occurred over a two-month period.<br><br>Member records showed four additional psychiatric hospital admissions occurred beyond the date range of the data provided by the team to reviewers. For these admissions, the team completed an emergent petition for one member, and another member self-admitted twice without the team being aware. There was no evidence of team involvement for the fourth admission. | • ACT teams performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. |

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| | | | The ACT team was directly involved in 70% of the most recent psychiatric hospital admissions that occurred over a two-month period. | |
| O6 | Responsibility for Hospital Discharge Planning | 1 - 5<br><br>4 | Staff reported direct involvement with psychiatric hospital discharge planning for members. Coordination with the inpatient team to schedule a staffing is completed upon admission, or notification of admission, and the team visits with the member in person every 72 hours, or by telehealth to discuss discharge planning and assess members' needs to prevent hospital re-admits.<br><br>Staff meet members at the hospital upon discharge and transport to their agreed upon desired location. Staff follow a five-day hospital discharge protocol that includes in-person contacts with the Psychiatric Nurse Practitioner, Nurse, and primary care provider within 72 hours. Members receive in-person contact with team staff daily, including weekends. During the program meeting observed, hospital visits and discharge planning were discussed by the team.<br><br>The team reported being involved in all of the ten most recent psychiatric hospital discharges that occurred over a two-month period.<br><br>Member records showed two additional psychiatric hospital discharges occurred beyond the date range of the data provided by the team to reviewers. For these discharges, there was no evidence of the team coordinating discharge planning or direct involvement in the discharge | • Increase involvement in psychiatric hospital discharge planning such that the team is involved in 95% or more member discharges.<br>• Consider peer review of documentation to ensure coordination of care, attempts, and successful contacts are accurately included in member records and conducted by direct service staff. |

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| | | | itself. One record showed documentation of the program assistant coordinating via email.<br><br>The ACT team was directly involved in 80% of the ten most recent psychiatric hospital discharges. | |
| O7 | Time-unlimited Services | 1 - 5<br><br>5 | Data provided showed one member graduated from the team with significant improvement in the past 12 months. Staff estimated seven to eight members are anticipated to graduate in the next 12 months. | |
| S1 | Community-based Services | 1 - 5<br><br>1 | Staff interviewed reported 80% or more of in-person contacts with members occur in the community.<br><br>The review of ten randomly selected member records shows that staff provided services in the community a median of 13% of the time. Records reviewed indicated that community-based services include home visits, hospital visits, transportation to the pharmacy, and attending intake appointments at a member's placement. Two member interviews revealed that the team has not delivered services in the community for a significant period, while another member reported receiving community visits from the team one to three times weekly. | • Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.<br>• Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts. Evaluate which clinic-based activities can transition to occur in the community. |
| S2 | No Drop-out Policy | 1 - 5<br><br>5 | According to data provided and reviewed with staff, the team did not have any members drop out of the program in the past year. The team retained 100% of the total number of members served in the past 12 months. | |
| S3 | Assertive Engagement Mechanisms | 1 - 5<br><br>4 | Staff interviewed stated that outreach efforts are initiated after the team has been unable to make contact with members for one week. When a member is identified as being on *outreach,* | • Increase assertive engagement efforts with members. Ideally, outreach is carried out by multiple ACT staff, drawing from motivational interviewing skills, allowing |

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| | | | efforts to engage members are made four times a week for eight consecutive weeks which includes two community attempts to locate and two attempts via phone or web-based collaborative portals. Staff indicated that building rapport is crucial for maintaining member engagement with the team. The outreach and engagement strategies utilized by the team involve visiting the last known address and locations frequented by the member, and coordinating with shelters, natural supports, the medical examiner's office, Arizona's Medicaid program portal, and probation officers.<br><br>Records reviewed revealed inconsistencies in the application of engagement and outreach efforts. Documentation showed that engagement lapses by ACT staff ranged from 7 to 16 days. The *8 Week Outreach Workflow* was provided for review, but not all staff were familiar with the policy. | members a diverse group with whom to connect and then documented in member records.<br>• Ensure all engagement and outreach efforts, including letters, phone calls, and contact with formal and natural supports are documented in member records.<br>• Consider identifying factors that would initiate immediate member follow-up from the team (e.g., missed psychiatric/nurse appointments, missing scheduled visits with staff specialists). |
| S4 | Intensity of Services | 1 - 5<br><br>3 | 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, is 78 minutes. The member with the highest weekly average duration had 190 minutes of service. The member with the lowest had 35 minutes. | • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Provide individualized support, including to members that elect not to participate in office-based groups. |
| S5 | Frequency of Contact | 1 – 5<br><br>3 | Of the ten records randomly sampled, ACT staff provided a median frequency of 2.00 in-person contacts to members per week. The range for frequency was 1.00 to 3.75 contacts weekly. None of the member records reviewed averaged four or more contacts per week. Median | • Increase the frequency of contact with members by ACT staff, optimally averaging four (4) or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have |

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| | | | duration of phone contact was .88 minutes in the month period reviewed.<br><br>*The fidelity tool does not accommodate delivery of telehealth services* | different needs/goals and frequency of contact should be determined by those needs and immediacy. |
| S6 | Work with Support System | 1 - 5<br><br>2 | All staff interviewed emphasized that family and natural support involvement is crucial to members' treatment, valuing their input, and recognizing them as key allies.<br><br>Staff identified 24 members as having natural supports and reported maintaining contact with these supports at least once a week, sometimes more frequently, noting that many members live with their natural supports. During the observed program meeting, discussions included staff contacts with members' natural supports.<br>Based on members interviewed, two reported having natural supports; one reported that the team does not have contact with their natural support, while the other indicated that the team had made contact in the past.<br><br>Member records reviewed revealed that for two members identified as having natural supports, there was no documentation of contact with these supports over the month period reviewed. A member not identified as having natural supports had three documented contacts with natural supports, resulting in an average of 0.30 contacts over the reviewed month. | • Evaluate methods of tracking or monitoring staff documentation of contacts with Natural Supports.<br>• Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four (4) per month for each member with a support system.<br>• Assist members in developing a natural, community-based support system. Active participation with peer run programs is a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact. |
| S7 | Individualized Co-Occurring | 1 - 5<br><br>4 | Staff reported that 36 members on the team roster have co-occurring disorders. It is estimated that 15 to 20 of these members | • Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders. Monitor member |

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| | Disorders Treatment | | participate in weekly structured individual counseling with the Co-Occurring Disorders Specialist.<br><br>Sessions range from 20 to 160 minutes. Fifty percent of the records reviewed identified members with co-occurring disorders, of those, there was one record with documented one-to-one individualized co-occurring disorders treatment session for 61 minutes. | engagement and participation in individual substance use treatment.<br>• Document the offering of services and the delivery of individual treatment to members with co-occurring disorders. Explore training on strategies to engage members in substance use treatment. |
| S8 | Co-Occurring Disorders Treatment Groups | 1 - 5<br><br>1 | At the time of the review, the team was not providing co-occurring disorders treatment groups. | • Optimally, 50% or more of members with a substance use disorder attend at least one co-occurring disorders treatment group each month. On ACT teams, all staff engage members with co-occurring disorders to participate in treatment groups, based on their stage of change, with content reflecting stage-wise treatment approaches.<br>• Co-occurring disorder treatment groups work best when based in an evidence-based practice (EBP) treatment model. Consider structuring groups around proven curriculum for optimal impact.<br>• Consider offering groups so that at least one is structured for members in earlier stages, and 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<br><br>2 | Staff interviews indicated that the team adopts a non-judgmental approach when addressing members with substance use disorders. Most staff reported using harm reduction strategies | • Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as *Integrated Co-Occurring Disorders* |

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| | | | when working with members with co-occurring disorders, though some indicated that abstinence was the primary goal. Some staff were less familiar with the principle of a stage-wise treatment approach for co-occurring disorders.<br><br>Documented interactions and treatment plans in member records predominantly cited traditional model terminology, such as "sober" and "sobriety." The team supports members who wish to attend peer-run substance use programs as there is no group treatment available from the team. Members are referred to detoxification facilities when medically necessary. Observations from the program meeting and staff interviews showed a mix of approaches; encouraging engagement with the Co-Occurring Disorders Specialist for individual and group substance use treatment, and multiple references to consideration of inpatient treatment for members with co-occurring disorders.<br><br>Of the five records of members with co-occurring disorders, one treatment plan detailed interventions how the team would support the member in achieving recovery goals. Three treatment plans noted that the member would meet with team staff for substance use treatment. One treatment plan did not include any substance use treatment goals.<br><br>Education on co-occurring disorders is provided by the Prescriber when inquiries arise. Staff reported completing co-occurring disorders | *Treatment*, in the principles of a *stage-wise approach* to interventions, the EBP of *harm reduction,* and *motivational interviewing.* With staff turnover, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Identifying a co-occurring disorders treatment model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in recovery.<br>• Ensure treatment plans are written from the member's point of view, recovery focused, and outline steps the team will take to address substance use while supporting the member in recovery.<br>• When creating treatment plans, support members to identify a *reduction of use* goal when a desire for abstinence is expressed. |

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| | | | training through *Relias,* and some have received in-person training provided by agency staff. | |
| S10 | Role of Consumers on Treatment Team | 1 - 5<br><br>5 | The team includes at least two staff members with lived or living psychiatric experience who advocate from a peer perspective and carry similar responsibilities as other ACT staff. Staff reported that sharing personal recovery stories with members helps establish a trusting connection and reassures members that they are not alone in their journey. Two interviewed members were knowledgeable about staff with lived or living psychiatric experience and indicated that this personal connection facilitates communication and is valuable. | |
| **Total Score:** | | **102** | | |

**ACT FIDELITY SCALE SCORE SHEET**

| Human Resources | Rating Range | Score (1-5) |
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| 1. Small Caseload | 1-5 | 5 |
| 2. Team Approach | 1-5 | 4 |
| 3. Program Meeting | 1-5 | 5 |
| 4. Practicing ACT Leader | 1-5 | 3 |
| 5. Continuity of Staffing | 1-5 | 2 |
| 6. Staff Capacity | 1-5 | 3 |
| 7. Psychiatrist on Team | 1-5 | 5 |
| 8. Nurse on Team | 1-5 | 5 |
| 9. Co-Occurring Disorders Specialist on Team | 1-5 | 2 |
| 10. Vocational Specialist on Team | 1-5 | 2 |
| 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 | 4 |

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| 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 | 5 |
| 3. Assertive Engagement Mechanisms | 1-5 | 4 |
| 4. Intensity of Service | 1-5 | 3 |
| 5. Frequency of Contact | 1-5 | 3 |
| 6. Work with Support System | 1-5 | 2 |
| 7. Individualized Co-Occurring Disorders Treatment | 1-5 | 4 |
| 8. Co-occurring Disorders Treatment Groups | 1-5 | 1 |
| 9. Co-occurring Disorders Model | 1-5 | 2 |
| 10. Role of Consumers on Treatment Team | 1-5 | 5 |
| **Total Score** | **3.64** | |
| **Highest Possible Score** | **5** | |