ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: December 22, 2020

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AHCCCS Fidelity Reviewers

Method

On November 16-17, 2020, T.J. Eggsware and Karen Voyer-Caravona completed a review of the Community Bridges, Inc. (CBI) 99th Ave. 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.

The 99th Ave ACT team is located in Avondale, Arizona at a location that houses another ACT team, as well as a primary care provider (PCP). CBI also operates a third ACT team and three Forensic ACT (F-ACT) teams at other locations. 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.

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

The reviewers participated in the following activities:

- Observation of a daily ACT team meeting on November 16, 2020 via videoconference;
- Individual video interviews with the Clinical Coordinator (i.e., Team Leader), Substance Abuse Specialist (SAS), ACT Specialist (AS) and Housing Specialist (HS);
- Individual telephone interviews with five members who receive ACT services;
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of documents: the Regional Behavioral Health Authority (RBHA) *ACT Admission Criteria*; the team *Outreach Template* form,

resumes and training records, the CC encounter report, substance use treatment resources, and substance use treatment 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 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 Psychiatrist is fully dedicated to the ACT team with no other duties outside the team. Staff said that the Psychiatrist is responsive, and accessible to staff, including after hours and on weekends, when the need arises.
- Staff is available to provide crisis support. The specialists rotate on-call phone coverage daily. Members said that staff provided them with the on-call number and are responsive.
- The team maintained consistency and continuity of care for members with a low monthly admission rate, and few members transitioned off the team over the year prior to review.
- Staff documented multiple natural/informal support contacts in the records reviewed.

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

- Attempt to identify factors that contributed to staff turnover or supported retention. With nine staff, the team does not meet minimum standards for an appropriate member to staff caseload ratio and to provide necessary coverage to the 98 members served. Over the year prior to review, certain positions remained vacant for multiple months, including Nurse, SAS, and Peer Support Specialist.
- Support members who are in staffed residences to explore more independent housing options, as appropriate, with ACT staff as their primary support.
- Provide regular training and guidance to vocational staff related to supports and best practices that aid members to obtain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, and follow-along supports. ACT vocational staff should directly provide the full range of employment services.
- As public health conditions improve, evaluate how the team can support members who receive a lower intensity and frequency of service. Under typical circumstances, the ACT team should provide members an average of four or more face-to-face contacts, and two hours or more of face-to-face contact weekly. In sample records, over a month period, some members received infrequent contact, or, lapses in contact or outreach. Ideally, services are individualized and primarily community-based. The ability of staff to perform certain community-based contacts may be impacted by changing public health guidance.

- The team should continue their efforts to engage members in individual and group substance use treatment, in as safe a manner as possible, as community health conditions allow.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team serves 98 members with eight staff who provide direct services. Excluding the Psychiatrist and Program Assistant, the member to staff ratio is about 12:1.	• Ensure necessary staffing for a member to staff ration of no greater than 10:1, excluding the Psychiatrist.
H2	Team Approach	1 – 5 5	Staff interviewed said that all members see more than one staff in a two-week period. Based on ten records reviewed, 90% of members met with more than one staff over a two-week period. Most members interviewed said they had contact with three to five staff the prior week. Staff are assigned caseloads, primarily for paperwork tasks, and are expected to make weekly contact with those members.	
H3	Program Meeting	1 – 5 5	Staff reported that the ACT team holds a program meeting five days a week. All members are discussed four days a week. On the fifth day, more in-depth discussions occur for certain members. During the meeting observed, the Program Assistant listed the name of members for discussion and identified certain elements of information including whether members were under probation or parole terms, court ordered treatment status, and stage of change for members with co-occurring substance use concerns. The Psychiatrist and Nurse work four ten-hour days and attend meetings on the days they are scheduled to work. The Psychiatrist or Nurse may leave the meeting early on occasion if member needs arise. During the team meeting observed via videoconference, staff contributed to updates on recent and/or planned contacts. There	• Evaluate if the standard data discussed during the meeting are necessary or could be documented on a shared meeting log. The time saved reviewing those data points might allow for discussing other aspects of member care. For example, the team may elect to document a member's stage of change on a shared log and an SAS would be tasked to notify the team if a change occurs. Other elements may infrequently change.

			was limited discussion of individualized elements of member statuses.	
H4	Practicing ACT Leader	1 – 5 2	Staff said that the CC provides direct services to members. In records reviewed, prior to the public health emergency, examples of CC direct services were documented. The CC conducted four home visits with one member and visited another member at a CBI facility. The CC made two office-based contacts with one member and one office-based contact with another member. CBI staff provided a graph that shows the CC's monthly contacts monthly January through October. It was not clear if the graph reflects only direct contact or how the percentages listed were determined. An encounter report of face-to-face contacts by the CC for October 2020 was provided that shows direct services accounted for about 4% of the CC's time. About half of the contacts were identified as home visits.	• Under ideal circumstances, the CC's delivery of direct services to members should account for at least 50% of the time. • Identify administrative tasks currently performed by the CC that can be transitioned to other administrative or support staff, if applicable.
H5	Continuity of Staffing	1 – 5 4	The team has 12 positions when fully staffed, not including the Program Assistant. Based on data provided, seven staff left the team in the most recent 24-month period. The staff turnover rate was about 29% over the two-year period. Based on records reviewed, multiple agency Nurses also provided service to members.	• Attempt to identify factors that contributed to staff turnover or supported 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.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 82% of staff capacity over the prior year. There was a total of 26 months with vacant positions. Certain positions remained vacant for multiple months, including Nurse, SAS, and Peer Support Specialist. One staff interviewed identified a pool Nurse who provided coverage on the team. The pool Nurse was not listed as a current staff on the team. Some staff spoke of the one current team Nurse. Records	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually.

			reviewed shows documentation from multiple agency Nurses. It was one clear that one Nurse regularly provided coverage.	
H7	Psychiatrist on Team	1 – 5 5	The team has a fully dedicated ACT Psychiatrist. The Psychiatrist provides all services via telemedicine. Staff and members spoke with positive regard about the Psychiatrist. Staff said that the Psychiatrist is accessible to staff, including after hours and on weekends, when the need arises. In addition to meetings, the team uses email, phone, and text to coordinate care. Staff said that the Psychiatrist reliably completes consultation with treating providers when members are inpatient.	
H8	Nurse on Team	1 – 5 3	The ACT team has one Nurse. Staff reported that the Nurse provides clinic and community-based services including injections, medication education, and coordination of care. Staff said that the Nurse is responsive and accessible, including over the weekend and after hours. Prior Nurses left the team during January 2020 and November 2019. One staff said a pool Nurse provided coverage on the team. Another staff said that multiple Nurses provided coverage. Staff said that a new Nurse was hired and began New Employee Orientation the week of the review.	• Ensure ACT team coverage at two 100% dedicated, full-time nurses per 100 members. • Identify and find solutions to factors that may contribute to staff retention in the nursing role.
H9	Substance Abuse Specialist on Team	1 – 5 3	Staff reported that the team has one SAS who joined the team July 2019. The SAS was employed with CBI in other departments before joining the ACT team. Per the staff's resume, one of those positions duties was to facilitate and coordinate enrollment in medication assisted treatment. The SAS's resume shows that the staff attained two Master of Science Degrees, in Professional Counseling and Psychology. The SAS's training	• Ensure both SASs receive regular training and supervision in providing treatment to members with co-occurring diagnoses.

			record show participation in applicable trainings, such as Working With Persons With Mental Illness and Co-Occurring Disorders, Integrated Treatment for Co-Occurring Disorders, and Motivational Interviewing. The second SAS was recently hired and started with the team the week of the review. It is not clear if the second SAS has prior experience in providing treatment to members with co-occurring diagnoses. The second SASs records provided show recent training in Substance Use & Dependence and Motivational Interviewing.	
H10	Vocational Specialist on Team	1 – 5 2	The ACT team has one vocational staff, an Employment Specialist (ES), who has been with the team since September 2019. The ES previously worked as an Integrated Case Manager, Community Health Worker, and as a Clinical Care Manager with transitional age youth. It does not appear that the staff has prior experience in assisting individuals with an SMI diagnoses to obtain and maintain competitive employment. The staff's training record shows few applicable trainings since September 2019, such as Employment Rehabilitation, and Employment Training for ACT Vocational Specialist.	• Fill the second vocational specialist position. • Provide ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid members to obtain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, employer engagement, and follow-along supports.
H11	Program Size	1 – 5 4	With nine staff, not including the Program Assistant, the team does not have the minimum number of staff to provide coverage to the 98-member roster.	• Continue efforts to hire and retain qualified staff.
O1	Explicit Admission Criteria	1 – 5 5	The team uses the RBHA's *ACT Admission Criteria* tool. Staff said that the CC and other specialists conduct screenings. Staff reported that the team employs a three-stage screening process. Three staff contacts occur with referred members to	

			screen and discuss ACT services. Staff reported that some members decline ACT during the first contact due to the intensity of ACT, but reconsider and accept ACT during the second or third contact. Staff said that members are referred to the team from Supportive level treatment teams, inpatient provider staff, prison discharge planners, and newly determined SMI members referred through Crisis Preparation and Recovery. Staff reported that the team Psychiatrist conducts doctor-to-doctor contact with the referring provider. Staff have not needed to engage in recruitment of member referrals to ACT due to regularly receiving new referrals.	
O2	Intake Rate	1 – 5 5	Over the prior six months, the peak member admission was four members during September 2020. There were two admissions during October, one admission each month during May, July, and August, and zero admissions June 2020.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services, substance use treatment, and psychotherapy/counseling. Employment/rehabilitative support services are available. Staff said that about five to seven members receive counseling through the SAS, and none receive counseling from other agencies. During the team meeting, staff identified a few members who receive counseling. Examples of individual substance use treatment or engagement was found in some applicable records reviewed. The team provides in-home services and assists members with housing options if the need arises. Staff approximation of how many members are in staffed residences ranged from about 7% to 15%.	• Continue to track the number of members in staffed residences. As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team. Optimally, no more than 10% of ACT members are in settings where other social service staff provides support. • When a second vocational staff joins the team, and with additional training in vocational supports that enable members to obtain competitive employment, the team should be able to enhance the scope of employment support service available.

			The settings include formal treatment settings (e.g., residential) and residences with staff or house managers. Employment support is available through the team's ES. One staff said that about five members are seeking employment and about six are members are employed. One staff said that Vocational Rehabilitation staff may refer members to outside vocational service providers. One staff said that a member may receive service from an outside provider. Based on interviews and records, employment supports include meeting with members and offering vocational rehabilitation. There was limited evidence of vocational staff directly providing other employment services.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team has full responsibility for crisis services. The ACT team has an on-call system which rotates daily between specialists. The CC serves as a resource and can discuss issues with other agency management if the need arises. Staff said that when members join the team, they receive a document with staff phone numbers and the on-call number. Interviewees reported that members are also provided with a business card that lists the on-call phone number. Staff said that they inform members' natural supports of staff on-call availability. Members confirmed that staff is responsive to after hour calls. If needed, staff will respond to members in the field, and that approach did not change during the course of the public health emergency.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff reported that during office hours, the Nurse and/or team Psychiatrist is involved in decisions on member hospital admissions. The member may	• Maintain regular contact with all members and their support networks (both informal/natural and formal). This may

			meet with the Psychiatrist via video to assess the member or adjust medications. ACT staff may also seek to have a member assessed or receive inpatient treatment by completing petitions for Court Ordered Evaluation or by amending members' existing Court Ordered Treatment. The petition or amendment process occurred for five of the ten most recent member inpatient admissions based on information provided. Staff said that some members self-admit. Two staff said that the team was involved in 90% of recent admissions. Another staff estimated a higher number of recent circumstances where the team was not involved in admissions, about six or seven. Based on data provided, of the ten most recent inpatient admissions, one member self-admitted and the team learned later of the admission. Another member self-admitted to an emergency room and was transferred for behavioral health service at a different facility. ACT staff reported that the team coordinated with staff from there. ACT staff complete a *Continuity of Care* worksheet for inpatient members. Staff said that the Psychiatrist conducts doctor-to-doctor consultations with inpatient providers when members are hospitalized. During the public health emergency, visitor restrictions are in place at hospitals. Staff reported that every 72 hours the team communicates with inpatient staff and with members who are inpatient.	result in earlier identification of issues or concerns relating to members, allowing the team to offer additional supports, which may reduce the need for hospitalization. Develop plans with members in advance, especially if they have a history of hospitalization without seeking team support.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said that the team was directly involved in the ten most recent hospital discharges. Due to the public health emergency, staff are not allowed into hospitals when members discharge. Staff go	

			to a designated area at hospitals to pick up discharged members. Staff said that members are scheduled to meet with the Psychiatrist within 72 hours. The Psychiatrist does not work on Mondays. One staff said that when member's discharge on Friday, they meet with the Psychiatrist within 96 hours. Staff said that they attempt face-to-face contact with members for five days after discharge. Staff said that the team prefers to conduct the five-day follow-up in person as they found the approach more effective than video contact in those situations.	
O7	Time-unlimited Services	1 – 5 5	Staff reported that over the prior year, five members stepped down to Supportive level of treatment. Four of those members stepped down due to improvement and one was placed in a residential program. The member's guardian elected to follow that course of treatment and step-down the member from ACT. Staff projected no upcoming graduates.	
S1	Community-based Services	1 – 5 4	Staff said that the public health emergency impacted their ability to provide community-based services at the expected level (i.e., 80% or higher). A staff said that due to the public health emergency, about 50% of their time is spent in the community. Based on records reviewed for the identified timeframe prior to the public health emergency, services were provided to members in the community about 65% of the time.	• Under optimal circumstances, 80% or more of services occur in members' communities. As public health conditions improve, evaluate how the team can increase the frequency that services are delivered to members in the community.
S2	No Drop-out Policy	1 – 5 5	Few members left the team during the 12 months prior to review. Based on data provided, four members transitioned to *Navigator* status. One member left the geographic area without notifying	

			the team. Staff said that they were in contact with the member's natural support, attempted to determine the member's location, but that the natural support discontinued communication.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff provided the reviewers with a copy of their *Outreach Template* form. Staff said that the team follows a no-show follow-up protocol. If a member misses an appointment with the Psychiatrist, Nurse, Primary Care Physician or for counseling, they are added to the team's four-day follow-up. If the team is not able to make contact with the member by the fourth day, they are formally tracked for outreach or reengagement. Staff said that the team outreach efforts include visiting the member's last known location, contacting natural supports, and contacting agencies or system partners. Staff said that the team conducts four weekly outreach efforts, two of which are community-based. The *Outreach Template* form has space to track ten weeks of outreach, lists prompts for where or how to conduct outreach, and lists phone numbers for payees, jail information, drop-in centers, and hospitals. There were lapses in documented contact or outreach to members in some records reviewed. For one member more than a week lapsed between contacts. For the same member, during the same month, staff documented one outreach over a period of nine days. In another record, staff documented one home visit attempt and one phone attempt over about two weeks. For another member, staff documented two home visits and the member called the on-call one time over a ten -day timeframe. Staff documented one home visit	• Ideally, outreach should be carried out by multiple ACT staff and documented in the member's record. The program should evaluate if any recent changes to outreach processes or documentation show improvement from the period reviewed prior to the public health emergency. The program may determine if further enhancements are needed. • In addition to initiating outreach following missed appointments, consider other instances when outreach/engagement should occur. For example, consider initiating more aggressive outreach, using the team's Outreach Template, if there are lapses in contact with members.

			attempt and a phone call from another member over eight days. For another member, one home visit was documented, but no other outreach or contact was evident for nearly two weeks. For another member, staff documented one email and a phone contact over about a week period. For another member, staff documented one home visit attempt over about a week period.	
S4	Intensity of Services	1 – 5 2	In ten records reviewed, the median intensity of service time per member was about 48 minutes weekly over the month period reviewed, prior to the public health emergency. One of the ten members received an average of less than 15 minutes; three received less than 40 minutes average weekly service time; and none received more than 120 minutes service time per week.	• As public health conditions improve, evaluate how the team can support members who receive a lower intensity of service. Under typical circumstances, the ACT team should provide members an average of two hours of face-to-face contact weekly.
S5	Frequency of Contact	1 – 5 3	Based on records, on average, members received two weekly contacts with ACT staff during the identified timeframe reviewed, prior to the public health emergency. Due to the public health emergency, staff said that they work in the field and virtually, using phone or videoconference. One staff said that when staff conduct community visits, they meet outside or at the front door more often than prior to the public health emergency. Staff said that a program through the RBHA allowed some members to receive tablets, to accommodate telehealth services. Two members interviewed reported that they had underlying health conditions. The members said that staff contacts them by phone. One of the members said that staff contacts them by phone	• The team should continue their effort to contact members in as safe a manner as possible, as community health conditions allow. Optimally, ACT members receive an average of four or more face-to-face contacts a week. The number of contacts may vary, with some members receiving fewer and others receiving more contact depending on immediate and emerging needs. • Consider options to interact with members with safety measures in place. For example, some ACT teams visit member residences but interact using their phone. The approach allows for staff to maintain a safe distance from members and have face-to-face contact. • To maintain a diverse mix of staff contacts, some teams rotate specialist visits with members by location of their residences or

			once per week but that no one visited their residence since the beginning of the public health emergency. Other members reported a mix of phone and face-to-face contacts with staff. One member said that they live a significant distance from the clinic and that they had five phone contacts with staff during the seven days prior. Staff and most members said that if available, they are willing to use telehealth in the future. Staff cited benefits such as allowing flexibility and convenience for those members who prefer telehealth, are employed or in day programs for most of the day. One member said that in the past they travelled to the office in order to meet with the Psychiatrist by video. Being able to meet with the Psychiatrist over video from the member's home saves the member travel time. One member said that more frequent phone contact with staff was helpful. One member said they prefer to meet with staff face-to-face.	service needs. The approach can lend to members having contact with multiple specialists who can apply their specialty based on each member's goals and needs.
S6	Work with Support System	1 – 5 4	Staff interviewed estimated that 50% to 80% of members on the team have natural supports. Staff affirmed that there is at least monthly contact with each member's natural support network. One staff said that contact occurs at least weekly. The team works to provide education to members and their supports about public health guidance and safety measures. One staff said that due to the public health emergency, the agency seeks to limit the number of people in the lobby area. As a result, natural supports may not go to the office with members to attend appointments.	• Continue efforts to engage members' informal support systems as key contributors to the member's recovery team. Staff may be able to model recovery language and provide tips to family members and other natural supports on how they can support member treatment. • Regularly review member records to confirm that informal support contacts, including emails and phone calls, are documented.

			One of the five members interviewed said that ACT staff are in contact with their supports about once or twice a month. Two members said staff has contact with their family but were uncertain how often. One member was unsure whether or not staff makes contact with their natural supports, and one did not identify any natural supports. In ten records reviewed, staff averaged 2.5 contacts with informal supports over a month period. Staff documented nine contacts with one member's supports and twelve contacts with another member's support. Staff documented three natural support contacts for a third member and one contact with a fourth member's natural support. There were no informal support contacts for the other six members.	
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff said that the team serves 65 members with substance use diagnoses. Staff reported that the majority of those members, about 32 to 35, regularly receive individual treatment through the SAS but that some members receive counseling from other specialists. Specialist resumes and training records were provided, but it does not appear that all have attained a year or more of experience providing treatment to members with co-occurring diagnoses. Staff said that training and bi-weekly clinical supervision is provided. Based on training records, staff participated in some applicable training, such as American Society of Addiction Medicine (ASAM), Motivational Interviewing, and Integrated Treatment for Co-Occurring Disorders.	• Train staff on strategies to engage members in individualized treatment as appropriate, based on their stage of treatment. Make available ongoing supervision by the SASs or other qualified staff to support the SASs' efforts to provide individual substance use treatment. If other specialists are expected to provide individual substance use treatment, more extensive training and supervision may be required to ensure they follow the same approach as the SASs.

			Clinical oversight is provided, but the content of the oversight could not be verified in training records provided. Training transcripts list dates of oversight, not sub-headings with topics. During the team meeting observed, staff cited individual substance use treatment for a small number of members. Of the ten records, eight applicable members have substance use diagnoses. None of the eight members received four sessions over the month period. Records reviewed showed nine total individual sessions and one attempted session during the month period for the eight members with co-occurring diagnoses. No sessions were documented for three of the applicable members. Two members each received three sessions during the month. Three applicable members received one session each during the month and a second attempt was documented for one of those members. Sessions were only documented by SASs, not other specialists. Staff said session length can range from 20 to 60 minutes. Based on records, documented session times averaged about 38 minutes for the nine sessions. Based on these factors, it is estimated that the 65 members with co-occurring diagnoses received an average of less than 15 minutes per member of weekly substance use treatment.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff said that they offer one group targeted to members with co-occurring diagnoses. Staff said that in-person groups are held, but some members are reluctant to attend due to the public health emergency. Staff offers an option to members that	• The team should continue their efforts to engage members in group substance use treatment, in as safe a manner as possible, as community health conditions allow. The SASs should continue to collaborate with

			allows for remote participation. Staff said no members have participated using that option. One staff said that group size ranges from three to five members, roughly the same as prior to the public health emergency. Staff said that four to five different members attended group in the month prior to the review. Sign-in sheets for October 2020 show ten members who attended listed on the ACT roster, or about 15% of members with co-occurring diagnoses. Two members who participated were not located on the member roster. It was unclear if they left the team or are served by the location's other ACT team.	other specialists to engage members in co-occurring group participation with the goal of at least 50% of members with co-occurring diagnoses.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Staff said that the team uses Integrated Dual Disorder Treatment (IDDT). One staff said that they also draw from cognitive behavioral therapy (CBT) and client centered therapy. Based on observation and interviews, staff seems to approach treatment with an emphasis on harm reduction and acceptance of members' varied levels of readiness to change. Staff interviewed seemed to be familiar with stages of change. In the program meeting observed, staff discussed applicable members' stages of change. It is not clear how familiar all staff are with a stage-wise approach. Documentation in records reviewed showed infrequent evidence of staff addressing members' substance use concerns using stage-wise interventions and language. Most of the applicable member treatment plans reviewed addressed substance use and treatment. When substance use was addressed, individual	• Provide ongoing guidance to all staff in a stage-wise approach to treatment, including how engagement, persuasion, active treatment, and relapse prevention can enhance their use of the stages of change model. Discuss with staff how interventions align with a member's stage of change and treatment, and how to reflect that treatment language when documenting the service. Stage wise treatment and interventions is an important element of IDDT.

			treatment was usually listed as an intervention. Completing drug screening was also listed on some plans. For one member, the plan was to refer to residential substance use treatment. Sobriety was listed as a focus on some plans, but with language indicating it was the goal of those members. Staff said they do not refer members to AA or similar programs but that some members elect to participate. Staff provide members with a list of group if requested. Staff said that if they have concerns about a member's potential for withdrawal the team Nurse assesses the member. One staff said that the team may refer members to withdrawal management (i.e., detox) when medically necessary, based on certain substances of concern (e.g., benzodiazepines and alcohol). One staff said that the agency has a detox program, but the staff could not recall a time when an ACT member was referred there by the team.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The perspective of person's with lived experience is represented on the team. One staff said there was at least one employee on the team with direct lived experience of psychiatric recovery and that a staff on the team is a family member of a person with lived experience. One staff said that multiple employees on the team have direct lived experience of psychiatric recovery. One of the members interviewed said that there are many staff on the team with personal lived experience. Another member said that they believed there is staff on the team with lived experience. Three members were unsure if any	• Continue efforts to educate members, as applicable and appropriate, about staff on the team with lived experience who may serve as a resource.

			staff has lived experience, but one of those members said that staff conveys understanding for the member's experiences.	

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	4
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	2
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	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	4
6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	4
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	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.96**	
Highest Possible Score	**5**	