ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Eric Rathburn, Clinical Coordinator
John Hogeboom, Chief Executive Officer

From: Nicole Eastin, BS
Jasmine Davis, MS
AHCCCS Fidelity Reviewers

Introduction

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

Method

On March 28 - 29, 2023 Fidelity Reviewers completed a review of the Community Bridges Incorporated (CBI) Avondale 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.

Community Bridges, Inc. (CBI) operates several locations throughout Arizona. Services include supportive housing, crisis stabilization, ACT, and integrated healthcare. The agency operates three F-ACT teams and three ACT teams in the Central Region of Arizona. The individuals served through the agency are referred to as "*clients*" or "*patients*", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

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

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

- Remote observation of an ACT team program meeting on March 29, 2023.
- Individual video conference interview with the Clinical Coordinator (CC).
- Individual video conference interviews with Peer Support and Independent Living Specialists, as well as the Nurse for the team. One other Specialist was unable to attend the interview as scheduled.
- Individual phone interviews with four members participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; resumes and training records for Vocational staff; *ACT Contact Information; F-ACT Re-Engagement Policy; F-ACT and ACT No show follow up;* sign-in sheets for co-occurring disorder treatment groups; ACT team member roster; identification of Natural Supports; and CCs' Productivity Report.

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*).

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 ACT CC is highly engaged in providing direct services to members of the ACT team.
- The team has a clear admission policy, does not feel pressured to accept inappropriate referrals, and has a low admission rate.
- The team is available to provide crisis support by phone and in the community after business hours and provides weekend coverage. Members interviewed were knowledgeable of the team's availability and contact information after hours and weekends.
- The team has at least one staff with personal lived psychiatric experience. Two members interviewed reported that staff do share their stories of recovery, offering hope, encouragement, and a positive learning experience for their own recovery.

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

- Several positions on the team (two Co-Occurring Specialists, Housing Specialist, ACT Specialist, Nurse, and Rehabilitation Specialist) are vacant. Filling vacant positions as soon as possible helps to reduce the potential burden on team staff and improves continuity of care.
- Work to provide more frequent and intensive individualized services to members, with a focus on delivering those services in the community.
- The team would benefit from an improved understanding of co-occurring treatment services. Provide staff with annual training and ongoing mentoring in a co-occurring disorders model, the principles of a stage-wise approach to interventions, and motivational

interviewing. Ensure service plans are written in the members' points of view, reflect individual goals related to services provided and needed, and indicate the framework from which the services will be delivered by the team.

- Improve efforts to connect with member's natural supports, to an average of four per month for each member with a support system. Natural supports are a valuable resource to both members and the team.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 - 5 4	At the time of the review, there were 5.5 full-time equivalent (FTE) staff on the team, excluding Psychiatric Providers and the Program Assistant. It was reported there are 86 members on the team, leaving the member-to-staff ratio of approximately 16:1. The direct staff includes the CC, one Nurse, one Employment Specialist (ES), one Independent Living Specialist (ILS), one Peer Support Specialist, and a .5 temporary Peer Support Specialist (PSS).	• Optimally, the member-to-staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 - 5 2	Staff interviewed estimated that 75% of members are seen by more than one staff in a two-week period. Staff are assigned a weekly rotation of members to be seen. The team tracks contact during the program meeting on member calendars. During the program meeting observed, member calendars were shared on the videoconferencing platform. When the team reviewed each member, contacts that were scheduled and completed were documented, but did not specify how the contact was completed, i.e., in-person, phone, etc. Staff stated a report is pulled weekly that shows the last date, type, and location of service delivered to members. Staff reported that due to the high burden of service delivery, documentation is not being entered into member records in a timely manner. Of ten randomly selected member records reviewed for a month period, a median of 30% received in-person contact from more than one staff in a two-week period.	• Ideally, 90% of ACT members have 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 in two weeks; a diversity of staff allows members access to unique perspectives and expertise of staff. • Consider steps to improve the process already in place used during the program meeting to track contacts with members to increase contact with a diversity of staff. • It may be useful to assign one staff to spot-check documentation in member records to confirm recent attempts and successful contacts are entered in a timely manner.

H3	Program Meeting	1 - 5 5	ACT staff interviewed reported that the team meets five days a week and all staff are expected to attend the meetings on days scheduled to work. The team offers a hybrid team meeting allowing staff to join in-person, by phone, or through videoconferencing to accommodate staff out in the community delivering services. One of the five days, the team meets to discuss member needs more in-depth. During the program meeting observed, both the ACT Fidelity Specialist and the SMI Services Manager were present. The team reported the ACT Fidelity Specialist attends daily, and the SMI Services Manager attends occasionally. In addition, while the ACT Prescriber is on extended leave, three Psychiatric Providers have been identified to provide coverage and were in attendance to review members assigned. The CC provided direction to staff to follow up on member needs. All members on the ACT roster were discussed. Stages of change for members with a co-occurring diagnosis were identified and members with a natural support were identified. The team identified housing goals, needs, and updates on housing applications, reported on employment goals, status, and needs, described last contact and planned contact with members, reviewed scheduled and missed appointments, and updates on referrals.	
H4	Practicing ACT Leader	1 - 5 5	The CC reported providing direct services averaging 10 hours per week. Staff reported that the CC is readily available to staff and members. Documentation of the CC's productivity for a month period showed 45 hours of in-person services delivered. In the ten records reviewed,	

			there were four examples of the CC delivering direct services which included videoconference with an incarcerated member and providing engagement and support at the clinic. Additionally, the CC attended a hospital discharge staffing, physical outreach in the community, attempted phone calls to members, and coordination of care calls. Members interviewed expressed appreciation for the services provided by the CC. *The fidelity tool does not accommodate delivery of telehealth services.*	
H5	Continuity of Staffing	1 - 5 2	Based on the data provided, 15 staff left the team in the past two years, resulting in a turnover rate of 63%. All members interviewed expressed gratitude for the longevity and services provided by a few select staff on the team, but also expressed concern regarding the turnover of staff.	● If not done so already, consider examining 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.
H6	Staff Capacity	1 - 5 2	The team operated at 60% staff capacity during the prior year. Per data reviewed with the CC, seven positions were vacant anywhere from 3 – 12 months for the past 12 months. One of the Co-Occurring Specialist positions and one Nurse position have been vacant for 12 months, the PSS position was vacant for 10 months.	● To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible with the goal of operating at 95%, or more, of full staffing annually. Timely filling of vacant positions also helps to reduce the potential burden on staff.
H7	Psychiatrist on Team	1 - 5 4	At the time of the review, the ACT Prescriber was on leave. There are three .25 FTE CBI providers temporarily providing coverage to the team, and each attend at least one program meeting per	● ACT teams have at least one full-time, fully integrated Psychiatrist assigned to serve as the medical director for the team.

			week. The ACT team roster is split amongst the three covering providers. The members are seen by the same provider to ensure consistency, and services are delivered via teleconference. The team facilitates teleconference appointments with the covering providers at the clinic. During business hours, the covering providers are available by phone, email, and messaging application. After hours and weekends, one of the three providers is available to support the team. Per record review, four of the ten members were seen by the ACT Prescriber or the covering providers in the 30-day period reviewed. Three members interviewed were not certain which covering provider they would be scheduled with while the ACT Prescriber is out of the office. One member reported meeting with a covering provider.	• Ensure members are aware which covering provider they will be receiving their psychiatric care from and when they will be seen.
H8	Nurse on Team	1 - 5 3	The ACT team has one Nurse to support the care of 86 members. The Nurse works 11-hour days, Wednesday through Friday. Staff interviewed reported that the Nurse is readily accessible to the team by phone, email, in-person, and is available after hours and weekends to consult and provide support to the members and team. The Nurse provides services at the clinic on the days scheduled, and in the community one to two days a week in the afternoon. Aside from attending the program meeting, the Nurse provides medication oversight, administers injections, case management, schedules appointments, attends medical appointments with members, and coordinates care with inpatient teams, Primary Care Physicians, and natural supports.	• Continue efforts to recruit and retain Nurses to ensure consistency of coverage for clinic-based services, as well as community-based services. Having two full time nurses is a critical ingredient of a successful ACT program.

			Members interviewed reported seeing the Nurse at the clinic every other week to once a month. Per review of records over a 30-day period, the Nurse was active with nine members in-person at the clinic, in the community, and via phone.	
H9	Co-Occurring Specialist on Team	1 - 5 1	At the time of the review, the two Co-Occurring Specialist positions were vacant.	• ACT teams have two Co-Occurring Specialists assigned to provide services to members. When screening potential candidates for the position, consider a year or more of experience working with members with a co-occurring disorder and integrated care. The COS should have the capability to cross-train other ACT specialists in this area.
H10	Vocational Specialist on Team	1 - 5 2	At the time of the review, the team had one Vocational Specialist; the ES has been on the team for several years. No training related to assisting members in finding and retaining employment in an integrated work setting was located in training records provided for the ES.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Ensure vocational staff, regardless of experience, receive ongoing training and supervision in assisting people diagnosed with serious mental illness/co-occurring diagnoses to find and retain competitive employment. Training should include techniques to engage members to consider employment; job development strategies; the importance of supporting in-person employer contact soon after members express an employment goal; and the provision of follow-along support to employed members.
H11	Program Size	1 - 5 3	At the time of the review, the team had 6.25 staff, including temporary coverage by the three Providers and the PSS, to provide direct services to members of the team. Six positions were vacant at the time of the review, two Co-Occurring	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, a minimum of 10 direct service staff, allows the team to consistently provide diverse coverage; help to prevent potential staff

			Specialists, Housing Specialist, ACT Specialist, Nurse, and Rehabilitation Specialist. *This item does not adjust for the size of the client/member roster.*	burn-out; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the delivery of comprehensive individualized services to each member. • When allocating staff partial assignment to an ACT team, continue to ensure those staff attend a minimum of two program meetings a week, and Psychiatric Providers attend at least once a week, to allow a transfer of knowledge relating to member care.
O1	Explicit Admission Criteria	1 - 5 5	The ACT team has a clearly defined target population. Based on ACT staff interviews, members are referred by other provider network organizations, other ACT and supportive teams, justice system agencies, hospitals, and the Regional Behavioral Health Authority. The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. Staff reported that the CC conducts initial screenings of members referred. Members that do not meet criteria on the first screening will be screened a second or third time. Other ACT staff will conduct the screening at that point. When a member meets criteria but declines to join the team, the member will be screened at least three times and by more than one staff to provide a different perspective of the team's services. The Prescriber makes the final decision. Once the team has the members' approval to join the team, appointments are scheduled for treatment planning and a psychiatric evaluation. The team holds a staffing with the member, and the member is seen for a five day follow up by	

			different staff to acclimate the member to the team on the various roles of each staff and to offer services.	
O2	Intake Rate	1 - 5 5	Per data provided, and reviewed with staff, the team has an appropriate admissions rate. The month with the highest admissions rate during the past six months was February with three new members added to the team roster.	
O3	Full Responsibility for Treatment Services	1 - 5 2	At the time of the review, in addition to case management, the team provides psychiatric and medication management services. The team does not have staff with the ability to provide counseling/psychotherapy to members. Based on staff interviews, the team has nearly 12% of members residing in settings where ACT services are duplicated. One member interviewed advised that the CC is assisting the member in searching for housing. Two other members reported knowing who on the team they would go to for housing assistance. The CC also facilitates a housing group for ACT members once a week. The team has at least six members receiving employment and rehabilitation services from a brokered provider. At the time of the review, staff reported that the team supports 20 members in job search and six members in maintaining employment. Members interviewed reported ACT staff would assist in employment and rehabilitative services should they choose to engage in those services. Based on staff interviews and the program meeting observed, staff support members with employment and rehabilitation	● Counseling/psychotherapy should be available to members on ACT teams provided by ACT staff. Consider exploring options to provide counseling services to members of the ACT team, either through new or currently existing ACT staff. ● 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, fewer than 10% of ACT members are in settings where other social service staff provides support. ● Educate staff on the benefits of ACT staff engaging and directly supporting members with rehabilitation and competitive employment goals rather than engaging them to participate in temporary Work Adjustment Training activities or employment services with brokered providers.

			work by obtaining vital documents, preparing for interviews, travel training, how to dress for an interview, resume building, job search, mock interviews, and job coaching. One member record reviewed showed the ES supporting the member in maintaining employment. The ACT team is not currently providing formal substance use treatment services to members. One member interviewed reported waiting for a new COS to resume treatment. A chart reviewed showed the member requesting information on substance use treatment and staff advised that they would connect with the team to locate resources.	● The team should fully assume responsibility for providing members with formal substance use treatment services.
O4	Responsibility for Crisis Services	1 - 5 5	Based on interviews, the ACT team is available to provide crisis services 24 hours a day, seven days a week. On-call responsibilities are rotated daily. The on-call phone number is also utilized by members to reach staff during business hours in addition to after-hours availability. Staff provided a copy of the *ACT Contact Information* given to members and natural supports that lists the on-call number, names, numbers, and scheduled work hours for each of the ACT Specialists, Program Assistant, and the CC, noting that the number does not accept text messages. All members interviewed were familiar with the ACT on-call services and three reported having used it in the past. Two members reported using the on-call service when they were stranded and needed transportation to their desired destination. All members provided unsolicited feedback on how the team is very responsive to	

			their needs and indicated they can call the team anytime on the on-call phone, or staff work phones, and the team will answer.	
O5	Responsibility for Hospital Admissions	1 - 5 3	Staff interviewed reported that when the team is involved in the decision to psychiatrically hospitalize members, members are staffed with the CC, and the member is asked to meet with the Prescriber to assess the appropriate level of care. When it is determined the member needs inpatient treatment, staff will transport the member and remain with them throughout the intake process. After hours, staff will meet members in the community, using CBI company vehicles, to assess the situation and consult with the CC and/or Psychiatric Provider for next steps. Notifications are received from members' health plans when holding Title 19 benefits, or the Health Information Exchange portal when a member self-admits, or the team is unaware of the admission. For Non-Title 19 members, most often the member will inform the inpatient team of the assignment to the ACT team and the team will be notified of the admission. Based on data provided and reviewed with staff, the team was directly involved in six of the ten most recent member psychiatric hospital admissions. These admissions occurred over a three-month period. Three members self-admitted, and one member was supported by staff at their residence without the team's knowledge until after admission. In addition, at least two additional psychiatric	● The team should identify and seek solutions to barriers to direct team involvement in member inpatient admissions. Assess the quality of the therapeutic alliance; maintain stance of acceptance with member's readiness to accept recommended resources, services and supports, including housing and shelter. Focus on building trust and rapport with both members and their natural supports to increase team responsibility for hospital admissions to 95% or more. ● Ensure staff are trained on appropriate documentation standards to ensure that services delivered are appropriately reflected in the members' medical records in a timely manner.

			admissions were in one member chart reviewed and showed the member self-admitting.	
O6	Responsibility for Hospital Discharge Planning	1 - 5 3	Per staff interviews the team coordinates with the inpatient team regarding a discharge plan within 24 hours of admission and a staffing is scheduled with the inpatient team as soon as possible. Ideally, staffing's include the member and most staffing's are held by videoconference. The team reported connecting with members every 72 hours either in-person, contingent on inpatient providers permitting outside visitors, or by phone. Doctor to doctor and nurse to nurse coordination with the inpatient team occurs within 24 – 72 hours of admission. Staff interviewed reported that when members are ready for discharge, the member is scheduled with the ACT Prescriber within 72 hours, Primary Care Physician within five days, and the Nurse within one week. ACT staff will meet the member at the inpatient facility, obtain discharge paperwork and transport the member to the destination of their choice. The team follows a five-day follow-up protocol with members, connecting with them in-person. Staff reported that at the time of the review, due to staff shortage, the team may contact the members by phone for the five-day follow-up. Based on data provided and reviewed with staff of the ten most recent hospital discharges, that occurred in a three-month period; eight of the ten members were discharged and transported by ACT staff, and one member was discharged by the ACT team and transported by the member's residence staff.	● Track member discharge coordination, including visits to members that are inpatient. This may prevent lapses of coordination with the treatment team which may result in earlier identification of issues or concerns relating to members, allowing the team an opportunity to offer additional supports. ● Ensure the team delivers post psychiatric hospital follow up services and support as described during interviews, and track on member calendars. ● Ensure that services attempted and delivered are appropriately reflected in the members' medical records in a timely manner.

			Based on the information provided and charts reviewed, evidence did not demonstrate what staff interviewed indicated. Consistent with staff reporting challenges of ensuring documentation is entered in a timely manner; lack of documentation located in the records was observed for discharge coordination of care, inpatient visits or phone calls, staffing's, and five day follow up. One member was seen by the Prescriber within the 72-hour timeframe, three members were seen by the Nurse within five days of discharge. Additionally, at least three hospital discharges were in one member chart reviewed that were not included in the data provided. In another record, the hospitalized member requested team visits. The member was not seen in-person while inpatient for at least 24 days.	
O7	Time-unlimited Services	1 - 5 5	Data provided to reviewers showed the ACT team had graduated five members during the past year. The team measures readiness for graduation by medication and appointment adherence, housing stability, employment and rehabilitation involvement, independent living skills, and no recent hospitalizations or crisis interventions. For members in agreement with graduating from the team, services are gradually decreased to assess how the member does with less intensive services.	
S1	Community-based Services	1 - 5 1	Staff interviewed reported 60 - 99% of in-person contact with members occurs in the community. The results of ten randomly selected member records reviewed show staff provided services a median of 0% of the time in the community. Based on the ten records reviewed, four members were seen in the community for a total of 11 visits in the month period reviewed.	● 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 to use resources in a natural, non-clinical setting.

			Members interviewed provided a range of being seen in the community by ACT staff twice a week, twice a month, and two members reported they have not seen staff from the team in the community for quite some time as the team is short staffed.	
S2	No Drop-out Policy	1 - 5 4	According to data provided, the team retained 89% of the members in the last 12 months. The ACT team identified eleven members that declined/refused services, could not be located, or were closed due to incarceration.	● ACT teams should ideally retain 95% of the entire caseload year to year. Work to retain membership in ACT.
S3	Assertive Engagement Mechanisms	1 - 5 3	Outreach is conducted at a minimum of four times a week for eight weeks, following the guidelines of the *F-ACT Re-Engagement Policy,* when the team loses contact with members. Efforts to re-engage members include two electronic outreaches a week by phone or email to the member, and two physical outreaches in the community. The team will contact member's natural supports, probation officers, guardians, payees, and jails, or hospitals. The team has access to search the Arizona Homeless Management Information System to seek information if a member has received services elsewhere. In addition, the team attempts to outreach at the member's last known address, locations the member is known to hang out, shelters, alleys, community dining halls, and payee offices. Based on records reviewed, street outreach efforts by staff were documented including specific cross streets, shelters, attempted home visits, and staff leaving a contact card on the door for one member to let them know they had stopped by. One record reviewed was an incarcerated member and during the review period, weekly visits were completed	● Ensure all outreach efforts, including letters, phone calls, and contact with formal and natural supports are documented in member records. Monitor documented outreach and contacts with members. It may be useful to assign one staff to spot-check documentation in member records during the team meeting to confirm recent contacts or outreach efforts are entered. This may enable the team to proactively assign staff to outreach in the event of lapses.

			despite the member not wanting to engage with the team. Other records lacked documentation of assertive efforts of outreach and engagement per the described approach and policy. Outreach efforts were inconsistently documented for one incarcerated member, another member had 10 days of no contact after a missed appointment with the team, and a third had no contact for 17 days from the ACT team.	
S4	Intensity of Services	1 - 5 2	Per a review of ten randomly selected member records during a month period before the fidelity review, the median amount of time the team spends in-person with members per week is 15.25 minutes. The average weekly service per member ranged from 0 to 111.15 minutes. All but one member chart reviewed averaged less than 33 minutes.	● Increase the duration of service delivery to members. ACT teams should provide an average of 2 or more hours of in-person services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 - 5 1	Of the ten records randomly sampled, ACT staff provided a median frequency of 0.63 in-person contacts to members per week. Eight members had phone contact documented in the records reviewed, and two member records showed delivery of services through videoconferencing. Contacts range from less than once per week to the highest frequency of two contacts for one member. Staff stated that in-person contact is limited despite the team's attempts due to low staffing.	● Increase the frequency of contact with members by ACT staff, to the extent possible, preferably averaging 4 or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have different needs/goals and frequency of contact should be determined by those needs and immediacy. ● Ensure staff are trained on appropriate documentation standards to ensure that services delivered are appropriately reflected in the members' medical records in a timely manner.

			The fidelity tool does not accommodate delivery of telehealth services.	● Consider utilizing member calendars as a snapshot of when, by whom, and the duration of services provided. This may improve service delivery to members.
S6	Work with Support System	1 - 5 2	Data provided by the team identified 55 members as having natural supports. Staff estimated regular contact with natural supports for 15 – 35 members. Not all staff interviewed could provide an average of how often the team works with natural supports for each member. Varied responses included staff working with natural supports all the time, once every other week, for members that are doing well the need is not there, and typically when completing outreach efforts. One staff reported informing natural supports of the team's availability for support. During the program meeting observed, natural supports were identified, and recent contact or planned contact was discussed. Based on ten member records reviewed, one member record showed three natural support contacts documented within the month period reviewed. Examples of contact with the natural support included the natural support attending a family counseling session and Psychiatric appointment with the member. One member record had a goal on their individual service plan to reconnect with their natural support. Member' reports ranged from monthly contact, as needed, to no contact with natural supports by the team.	● Increase contacts with natural supports to an average of four per month for each member with a support system. As much as possible, contacts with natural supports should occur during the natural course of delivery of services provided to members. Ensure consistent documentation of contacts with natural supports occurs, which includes contact by phone, email, and text, as well as in-person. ● The team may benefit from further training on the benefits of natural supports and strategies to assist members in building and engaging natural supports. Discuss with members the benefits of involving their supports in their treatment.
S7	Individualized Co-Occurring Disorder Treatment	1 - 5 2	Per interviews and data provided, there are 64 members on the team identified with a co-occurring disorder. Due to the two COS vacancies,	● After COS positions have been filled, work to provide an average of 24 minutes, or more, per week of formal individualized

			staff reported that no members are currently receiving structured individualized co-occurring disorder treatment. During the month period reviewed, and based on a report provided of individual substance use treatment sessions delivered by the COS that recently left the team, 12 members received individual substance use treatment sessions ranging 10 – 53 minutes each.	substance use treatment services for all members with a co-occurring disorder diagnosis.
S8	Co-Occurring Disorder Treatment Groups	1 - 5 2	At the time of the review, the team offered a co-occurring disorder treatment group to members of this ACT team once a week facilitated by a non-ACT staff. This agency staff attends the team program meeting once a week to report on members' participation. Sign-in sheets provided to reviewers for the month period reviewed showed 5% of members attended a co-occurring disorder group facilitated by the former COS. The team tracks attendance of co-occurring disorder group on member calendars.	● ACT members receive co-occurring disorder treatment services from ACT staff. ● Staff should continue to engage members with a co-occurring disorder to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring disorder group. ● 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, utilizing best practices in co-occurring disorder treatment.
S9	Co-Occurring Disorders Model	1 - 5 3	One staff interviewed was familiar with the stage-wise treatment approach to interventions and reported that when working with members with a co-occurring diagnosis, motivational interviewing and harm reduction approaches are utilized based on the member's stage of change and provided examples. Further, staff interviewed reported encouraging members to attend substance use treatment group, work towards employment rather than using drugs, encourage safety, and	● Provide all ACT team staff with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Treatment for Co-Occurring Disorders, the principles of stage-wise treatment, and motivational interviewing. With high turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Adhering to a co-occurring disorder

			provide active listening and support with no judgement when working with members with a co-occurring diagnosis. Some staff stated abstinence is the goal. Staff do not refer members to peer-run substance use programs but will support members that request to attend. When members request detoxification services, the team will refer to local resources. During the program meeting observed, the ACT staff provided members' stage of change for those diagnosed with a co-occurring diagnosis. Also observed was staff discussing one member that was using substances and the language used while addressing the members' challenges was not accepting or recovery focused, rather blaming and shaming, however the team did agree engaging the member with peer support services would be beneficial to provide support. Another member the team was discussing requested a referral for substance use treatment and the team questioned readiness. Based on the records reviewed, of the six members listed on the COD roster, three members' treatment plans reflected goals to support the members in substance use treatment. Two plans indicated the framework and services to be delivered by the team. One record reviewed showed the Prescriber encouraging a member to attend individual and group substance use treatment with the team.	model within the team can promote continuity in the approaches ACT specialists utilize when supporting members. ● Ensure treatment plans are from the member's point of view, recovery focused, and outlines steps the team will take to address substance use while supporting the member in recovery.
S10	Role of Consumers on Treatment Team	1 - 5 5	The ACT team has at least one staff with psychiatric lived experience and shares their stories with members when appropriate. Members interviewed were knowledgeable of	

			more than one staff on the team with lived psychiatric experience and reported that staff shares their story. One member indicated staff sharing their stories of recovery creates hope and encouragement for them. Another member reported listening to staff and seeing what they have accomplished in their life is a reality check for them and has created a positive learning experience.	
Total Score:		**86**		

ACT FIDELITY SCALE SCORE SHEET

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

5. Responsibility for Hospital Admissions	1-5	3
6. Responsibility for Hospital Discharge Planning	1-5	3
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	1
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	1
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.07**	
Highest Possible Score	**5**	