ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: March 31, 2020

To: Gail Salientes, MACT Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On March 9-10, 2020, T.J. Eggsware and Karen Voyer-Caravona completed a review of the Copa Health Medical Assertive Community Treatment (MACT) 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 MACT team was managed by Partners In Recovery. Since the prior fidelity review, Partners In Recovery merged with Marc Community Resources, Inc. and is now known as Copa Health. Copa Health operates seven outpatient treatment centers serving individuals with Serious Mental Illness (SMI), including the West Indian School Campus where the MACT team is located. The MACT team works to integrate behavioral health services and medical care. The team's Primary Care Physician (PCP) works at the West Valley Campus Integrated Health Home.
The individuals served through the agency are referred to as *behavioral health recipients* and *members*, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

During the site visit, reviewers participated in the following activities:

- Observation of a daily team meeting on March 9, 2020;
- Individual interviews with the Clinical Coordinator (i.e., Team Lead), Lead Substance Abuse Specialist (SAS), Individual Living Skills (ILS) Specialist and Housing Specialist (HS);
- Group interview with three members;
- Charts were reviewed for ten randomly selected members using the agency's electronic medical records system; and,
- Review of documents, including: Clinical Coordinator (CC) face-to-face service tracking report, resumes and training records for the SASs and vocational staff, substance use treatment resources, individual and group substance use treatment participation tracking, staff contact brochure, the *MACT Morning Meeting Log*, agency policies *PRG.05 Inpatient Discharge/Transition Management* and *PRG.40 Re-Engagement, Transition and Closure*, and the Regional Behavioral Health Authority (RBHA) *Medical - ACT Admission Screening* tool.

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

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- All 12 staff positions are filled. The team is of sufficient size to provide the necessary coverage to the 90 members served. The member-to-staff ratio is about 8:1.
- Staff is available to provide crisis support. The specialists rotate working weekend hours and on-call coverage daily, with the ability to meet members in the community. The CC is available for consultation and back-up coverage. Members interviewed 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 admission and drop-out rate for the period reviewed.
- The team collaboratively works to support members to address medical health issues. For example, during home visits, a team Nurse discussed with a member their medical appointments and treatment. One staff attended multiple appointments with a member who received vision treatments.

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

- Evaluate what prevented staff from directly supporting members during hospital admissions. Maintain regular contact with members and their support networks, which might result in the identification of issues or concerns that could potentially lead to hospitalization. Develop individualized plans with members who access inpatient treatment without team support.
- Increase support to members that receive a lower intensity and frequency of service. Evaluate the engagement strategies employed by the team. In sample records, over a month period, staff documented frequent invitations to some members to participate in clinic-based groups. When members declined clinic-based groups, documentation showed less focus on staff attempts to identify activities or resources in the members' communities.
- Increase engagement with natural supports as partners in supporting members' recovery goals. Training staff on strategies for engaging informal support may be helpful. Staff may then be able to advise informal supports on how they can reinforce healthy recovery behaviors or use recovery language when they interact with members.
- Engage members diagnosed with co-occurring substance use diagnoses to participate in co-occurring treatment. Evaluate options to offer groups and individual treatment.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 90 members with 11 staff that provide direct services, resulting in a member to staff ratio of 8:1. Staff said that the Program Assistant (PA) provides direct services to members about 10% of their time. An agency staff, at the office one day weekly, is available to provide counseling services to members. The team Psychiatrist, PA, PCP and the agency counselor, were not factored into the member to staff ratio.	
H2	Team Approach	1 – 5 4	Staff said that nearly all members likely receive face-to-face contact with multiple staff in a two-week period. Staff are required to complete weekly home visits with their assigned caseloads. Members interviewed reported meeting with three to five staff, or more, during a recent week period. The members reported they frequently visit the office to participate in groups. Based on sample records, 80% of members received face-to-face contact with more than one staff over a two-week period.	• Confirm that attempts and contacts are documented. Ideally, 90% or more members have contact with more than one staff over a two-week period. The team should plan to engage and maintain contact with members who elect to not participate in group activities.
H3	Program Meeting	1 – 5 5	Per staff report, all members are discussed during the program meeting held five days a week. The Psychiatrist, Nurses and specialists attend meetings on their scheduled workdays. The Wednesday meeting time is extended to discuss members with more acute challenges and to meet with the team's affiliated PCP. During the meeting observed, all members were discussed. The CC listed members for discussion and led the meeting. Staff contributed by reporting on recent or planned contact with members, their efforts to engage certain members, and assistance provided to members to address medical issues.	

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H4	Practicing ACT Leader	1 – 5 4	Based on records reviewed, observation of the team, and documentation tracking provide, the CC regularly provides direct services to members. The CC reported providing direct services 80% of the time. Based on review of a productivity report, the CC provided direct services about 36% of the time over a recent month. Multiple examples of the CC providing direct services were documented in sample records. The CC documented office and community-based services, outreach, and engaging members to work toward their goals. For example, a member voiced an employment goal and the CC revisited the topic during subsequent contacts during the month period reviewed.	• Optimally, 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.
H5	Continuity of Staffing	1 – 5 4	Based on data provided, five staff left the team in the most recent two-year period. An agency float staff also provided coverage. As a result, the members experienced 25% turnover in staff. During the two years prior to review, multiple staff filled the vocational and SAS positions.	• 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 about 84% of staff capacity over the prior year. There was a total of 23 months with position vacancies. Positions vacant for multiple months include: Peer Support Specialist (PSS), Employment Specialist (ES), and SAS. Five staff joined the team since September 2019.	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually.
H7	Psychiatrist on Team	1 – 5 5	The team has one full time Psychiatrist, with the team since October 2016. Staff affirmed that the Psychiatrist only serves MACT members and does not have any administrative or lead responsibilities outside of the team. The Psychiatrist works four, ten-hour days. Staff said that the Psychiatrist is accessible. Staff can contact the Psychiatrist on days off, weekends, and after	

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			hours. Those contacts are usually coordinated through the CC or a team text application. Staff reported that the Psychiatrist meets members in the community one day weekly. Members interviewed confirmed that the Psychiatrist conducts home visits. One member said that the Psychiatrist once visited their home. No examples of community-based services from the Psychiatrist were found in ten records over a month period. Staff identify the Psychiatrist as a primary leader and decision maker on the team. During the team meeting observed, staff discussed a potential program graduate. The member was reluctant to transition off the team due to the positive impact of MACT services in their life. The Psychiatrist highlighted this point and coached the other staff to honor the member's service preference and recovery insight.	
H8	Nurse on Team	1 – 5 5	The team is staffed by two full time Nurses. Staff said that both Nurses share in the provision of behavioral and medical health care services. Staff said that the Nurses are available for consultation during office hours and after hours if needed. Staff reported that the Nurses provide office and community-based services. In ten member records reviewed a team Nurse documented providing services to members four times in the community over a month period. The Nurse documented picking up medications from the pharmacy and meeting with a member for home visits. During visits, the Nurse discussed the member's medical appointments and treatment.	

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H9	Substance Abuse Specialist on Team	1 – 5 4	The team is staffed with two SASs. The Lead SAS, who joined the team October 2019, is a Licensed Master of Social Work (LMSW). The Lead SAS previously worked with a different agency for nearly three years as a SAS. The Lead SAS reported receiving supervision from a licensed professional when employed at the prior agency. The Lead SAS reported currently receiving individual supervision from a Licensed Professional Counselor at Copa Health. The second SAS joined the team September 2019. The staff previously worked on a less intensive team as a case manager, including working with members with co-occurring diagnoses. However, it does not appear the second SAS attained at least one-year experience providing substance use treatment. The second SAS's training records showed participation in just over three hours training time in two substance use treatment topics: trauma and substance use, and motivational interviewing. Agency staff provided eight recent group supervision tracking notes for November 22, 2019 through February 28, 2020. Group supervision for agency SASs was led by a Licensed Clinical Social Worker. The Lead SAS attended three sessions and the second SAS attended seven sessions. Discussion topics include case presentations, building rapport, focusing treatment on the member identified goals, stage of change, and stage of treatment.	• Continue to provide supervision to both SASs in the agency's co-occurring treatment model, Integrated Dual Disorders Treatment (IDDT).
H10	Vocational Specialist on Team	1 – 5 2	The team employs a Rehabilitation Specialist (RS), with the team since September 2019, and an Employment Specialist (ES) who joined the team	• Ensure that both vocational staff receive training in assisting people diagnosed with

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			January 2020. Their resumes show that each have work histories in social service positions. It does not appear either had prior experience assisting individuals diagnosed with a serious mental illness (SMI) to obtain and maintain competitive employment. Staff said that RBHA staff provides on-site vocational training every three months. Training records showed few vocational services trainings. One staff participated in two pertinent trainings for a total of three hours and the other participated in five hours of relevant training.	SMI/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 face-to-face employer contacts soon after members express an employment goal; and, the provision of follow-along supports to employed members.
H11	Program Size	1 – 5 5	With 12 staff at the time of the review, the team is of adequate size to provide coverage to the 90 members. The team PA, PCP and the agency counselor are not factored into this item.	
O1	Explicit Admission Criteria	1 – 5 5	Staff said that members are referred to the team by hospitals through the RBHA, other agency teams, or other providers. The CC usually conducts screenings with members, but the Lead SAS or the HS may assess referred members. Staff screen members using the RBHA developed *Medical - ACT Admission Screening* tool. During the screening, staff explain to members about the frequency and intensity of ACT services. For admission to MACT, staff said that members must: meet general ACT admission criteria; join MACT voluntarily; agree to transition to the team affiliated PCP, and, be diagnosed with one or more of three medical conditions. Qualifying conditions for MACT admission are: Chronic Obstructive Pulmonary Disease (COPD), Diabetes (Type I or II), and Cardiovascular disease. In the criteria, Morbid Obesity and other chronic health conditions that require medical monitoring are also listed as qualifying conditions, but staff said members must	• Based on staff report of the team's admission criteria, update the *Medical - ACT Admission Screening* tool to reflect that referred members must be diagnosed with at least one of three primary medical conditions: COPD, Diabetes (Type I or II), and Cardiovascular disease.

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			have one of the three primary conditions.	
O2	Intake Rate	1 – 5 5	Over the prior six months, the peak member admission was three members per month during September 2019, January 2020, and February 2020. Two members joined the team December 2019. One member came to the team October 2019 and zero joined during November 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides case management, substance use treatment, and psychiatric and medication services. The SASs provide individual and group substance use treatment. Staff said that no members receive substance use treatment from an outside provider. Staff said that counseling is available through a counselor that works with members across all the agency's ACT teams. Staff reported that the counselor attends one full team meeting weekly to report on member statuses. Examples of services by the counselor were documented in member records reviewed. Based on staff report, between 7% and 12% of members are housed in staffed settings including treatment settings affiliated with the RBHA's system of care and other informal settings. The settings include locations where members may share rooms with others, may not have a lease, or may need to take part in programming or activities to remain in the setting. Staff in some settings may prepare meals for members or inform MACT staff if issues arise. Included in the number of members in staffed residences are two members in ACT affiliated housing, who may receive services/contacts by staff from other Copa Health ACT teams.	• Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with MACT staff providing housing support. Enlist natural supports as a resource to assist in identifying housing options. Members of the MACT team should be served by MACT staff. • Employment services should be provided to members by staff on the MACT team. Ensure that both vocational staff receive training in assisting members diagnosed with SMI/co-occurring diagnoses, to find and retain competitive employment. Trained vocational staff can then cross train team specialists.

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			The vocational staff on the team can help members with employment and rehabilitative goals. Staff said that seven to eight members are employed or participate in an education program. During the team meeting observed, staff discussed two members who receive employment services from another provider. Staff said that one member receives services from staff from a partner agency, so they do not need MACT staff employment support. Staff identified another member with a job coach through another provider, but said the service was in place before the member's transfer to MACT. A Staff interviewed said the team learned of the member's job coach service about two weeks prior to the review. In records reviewed, a different member's most recent service plan documented their participation in an employment program with a partner agency. Over a recent month period, MACT staff documented multiple discussions with the member about the employment services available through the partner agency's employment program. Staff reported no members receive services through the Division of Developmental Disabilities.	
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the team is available to provide crisis services 24 hours a day, seven days a week, including responding to members in the community. Specialists rotate working weekend shifts. On-call phone coverage rotates among specialists daily. The CC is available to consult with on-call staff and serves as back-up for after hour calls. Staff said they provide members with a contact list that includes the on-call and staff phone numbers. Members interviewed confirmed	• Update the team brochure with current staff names, and when staff leave or join the team. Some teams include contact numbers for each specialist on the team brochure/contact list.

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			that the team is available after business hours. A small brochure is available in the office. The brochure explains MACT staff names, positions, how they can help the member, and the team on-call number. The brochure listed the PSS and ES positions as vacant.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff said that the team follows the agency policy *PRG.05 Inpatient Discharge/Transition Management* to guide service delivery. During office hours, staff attempt to arrange for members to meet with the Psychiatrist and/or a Nurse for assessment prior to admission. MACT staff are available after hours to support members in the community or with inpatient admissions. Staff reported that they meet with members within 24 hours of being informed of an admission and every 72 hours afterward weekly Monday, Wednesday and Friday. Staff said that the Psychiatrist attempts doctor-to-doctor consultations with inpatient providers. Based on review of recent member psychiatric hospital admissions, the team was directly involved in eight of ten, with two members who self-admitted without contacting MACT staff.	• Evaluate what contributed to members not seeking team support prior to self-admissions. • Maintain regular contact with all members and their support networks (both informal/natural and formal). This may result in identification of issues or concerns relating to members, allowing the team to offer additional supports, which may reduce the need for hospitalization. • Consider if member treatment plans should be revised to address behaviors and/or circumstances related to self-admissions.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said that the team was directly involved in the ten most recent hospital discharges. Staff tracks post-hospitalization services during the daily team meeting. Staff said that members are scheduled to meet with the team Psychiatrist within 72 hours and Nurse within a week of discharge. Staff said that they attempt face-to-face contact with members for five days after discharge.	
O7	Time-unlimited	1 – 5	Staff reported that over the prior year, two	

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	Services	5	members graduated from the team and projected two graduates in the upcoming year. Staff said that transition plans are individualized, based on member needs, and include reducing MACT staff contacts prior to the service level change.	
S1	Community-based Services	1 – 5 4	Staff interviewed estimated spending 60-70% of their time in the community. Per the record review, a median of 65% of face-to-face contacts with members occurred in the community. Staff reported holding weekly office-based groups, one holds a two-hour group and the other holds two groups. Some members interviewed reported attending multiple office-based groups. Members said they enjoy the opportunity to receive support from others and establish friendships. In ten records reviewed staff frequently documented asking members to attend clinic-based groups. It does not appear that community-based activities were explored as often as clinic-oriented activities.	• Increase the delivery of services to members in their communities. Under optimal circumstances, 80% or more of services occur in members' communities. • The MACT team should deliver services in the community without relying too heavily on clinic-based group attendance. If new group activities are developed, avoid over-reliance on clinic contacts with members as a replacement for community-based contacts. Provide individualized services to support members to achieve their goals.
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the year prior to review, one member transitioned to *Navigator* status. Staff reported that no members refused services, could not be located, closed due to the team determining they could not be served, or moved from the geographic service area without referral. Two members receiving services from another system of care transitioned off the team.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The team reports to follow the agency policy *PRG.40 Re-Engagement, Transition and Closure*. The policy outlines the general expectations for a minimum of eight weeks of outreach for disengaged members. The policy includes expected steps for staff to take if members miss appointments. The policy does not appear to be specific to Assertive Community Treatment teams.	• Monitor documented outreach and contacts with members and evaluate the team's approach to building rapport with disengaged members. It may be useful to assign a staff to spot-check documentation in member records during the team meeting to confirm recent contacts or that outreach efforts are documented. This may

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			There were lapses in documented contact and outreach with members found in ten member records reviewed. A member missed an appointment with the Psychiatrist and follow-up was not documented until day five. Another member received two contacts over a ten-day period. An incarcerated member received three contacts over a month period. One member discharged from an inpatient setting during the month period reviewed. Staff assisted the member with their discharge. Staff attempted contact with the member the following day, without success. Staff documented their second attempt to the contact the member via text two days later. Staff documented a third outreach attempt to the member three days later and learned that the member was re-admitted to the hospital the prior evening.	enable the team to proactively assign staff to outreach members in the event of lapses in contact. • Continue efforts to involve informal supports as team partners in supporting members' recovery goals. • Consider aligning expectations for ACT team outreach and engagement with the RBHA's *Assertive Community Treatment (ACT) Operational Manual*.
S4	Intensity of Services	1 – 5 3	In ten records reviewed, the median intensity of service time per member was 83 minutes weekly over a month period. Three of the ten members received an average of 120 minutes or more per week. Four members received 66 minutes or less average time per week over a month period. The member who received the highest service intensity received most services in the office.	• Evaluate how the team can engage or enhance support to members who receive a lower intensity of service. Provide individualized support, including to members who elect not to participate in office-based groups. The ACT team should provide members an average of two hours of face-to-face contact weekly.
S5	Frequency of Contact	1 – 5 3	Members interviewed reported contact with three or more staff during a recent week period. A member reported their primary assigned staff visits with them in their home monthly. Members reported their contacts with staff occur more frequently in the office where they attend groups. The median weekly face-to-face contact was just under 2.9 per member based on records reviewed.	• Identify and resolve barriers to increasing contacts with members. Optimally, members receive an average of four or more face-to-face contacts a week.

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			Four members received an average of four or more contacts per week. Staff document interactions under separate codes based on services provided. When multiple notes document the same interaction, they are considered one contact for the purposes of this review.	
S6	Work with Support System	1 – 5 3	Staff interviewed estimated that 44% to 50% of members on the team have natural supports. Staff said that the team attempts at least weekly contact with members' informal support systems. Two members interviewed said that staff has regular contact with their family. One member said staff had made contact with their family. During the team meeting, staff discussed recent or planned contacts with informal supports for 14 members. In ten records reviewed, staff documented 16 contacts with member supports over a month period: five times each for three members, and once for a fourth member.	• The team may benefit from further training on strategies to assist members in building and engaging natural supports. • Educate informal supports about how they can support members' recovery. For example, assist them to identify community-based activities they can engage in with members. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors. • Ensure that all natural support contacts are documented in member records.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported that the SASs meet with about 40 of the 45 members with co-occurring diagnoses weekly. Staff said sessions time can vary (e.g., from five to 45 minutes), but that the goal is at least 20 minutes per encounter. Data showed nine of the ten members in the records sample have a substance use diagnosis. Some progress notes listed contacts as IDDT notes. In nine applicable records, a total of 16 IDDT notes were documented. Some IDDT notes were not documented by a SAS. It is not clear if the other MACT staff receives the same level of supervision and guidance in IDDT as the SASs.	• Work to increase the time spent in individual sessions and increase the number of members engaged so that the average time is 24 minutes or more across the group of members with co-occurring diagnoses. • Monitor time spent by the SASs in other duties, such as to members who do not have co-occurring diagnoses. Consider shifting those duties to other staff, if applicable.

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			The content of notes in one member's record showed treatment to process feelings related to loss and past trauma as well as to reinforce a sober lifestyle. Other IDDT notes documented general case management. Some notes showed staff offering groups with limited evidence of other treatment during the contact. Staff may miss opportunities to segue into discussions of substance use (e.g., role of ambivalence) when they provide other practical assistance to members. Individual session tracking from the agency electronic medical record was provided for a recent month period. Based on the average session time in records, and the individual treatment tracking data, the SASs provided about 15 minutes of substance use treatment weekly, on average, to members with co-occurring diagnoses.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 4	Staff said that each SAS facilitates a weekly co-occurring treatment group using the same curriculum module. Staff reported that 25-26 members attended at least one of the substance use treatment groups over a recent month period. Documentation in sample records showed staff inviting members to substance use treatment groups and two of the nine applicable members attended group. Based on records, and review of co-occurring treatment group sign-in sheets over a recent month period, about 36% of the 45 MACT members with co-occurring diagnoses attended group at least once. Based on review of co-occurring treatment sign-in sheets, the groups are not specific to members with co-occurring diagnoses. Many members	• Under optimal circumstances, 50% or more of applicable members participate in a co-occurring group. Optimally, face-to-face groups are preferred. Discuss options for dually diagnosed members to participate in group substance use treatment, such as small groups and/or using another format, if face-to-face contact is temporarily not recommended by local and/or federal health officials. Staff may benefit from training on strategies to engage members in group substance use treatment. • Evaluate the benefit of offering groups specifically for members with co-occurring diagnoses. There may be overlapping areas discussed in similar groups for members

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			without co-occurring diagnoses attended the groups. Some groups were attended primarily by members without co-occurring diagnoses. A social event at a park was hosted by MACT staff. Multiple varied group notes were documented for members. Staff presented on the purposes of the team's groups offered, but it is unclear what other treatment was provided.	without co-occurring diagnoses, but ideally co-occurring treatment groups should be attended by members with co-occurring diagnoses. • Some teams structure groups so that one is directed to members in earlier stages of treatment and another is targeted to members in later stages of recovery.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	During the meeting observed, the SASs referenced substance use treatment and invitations to members to attend group. Members' stages of change are included on the team meeting log. Staff reported that the team uses IDDT, an evidence-based practice for members with co-occurring SMI and substance use diagnoses. Staff is familiar with stage-wise treatment. A small poster with stage-wise treatment information is on the wall in multiple locations in the office. Staff interviewed gave examples of interventions for different stages of treatment. The agency provided to the team Dartmouth Psychiatric Research Center (PRC) Hazelden treatment manuals: *Integrated Dual Disorders Treatment (IDDT*), *IDDT Recovery Life Skills Program*, and *Illness Management and Recovery (IMR)*. Staff said that the team does not refer to Alcoholics Anonymous (AA) or similar groups as a primary intervention but has accompanied a member to meetings. Staff identified circumstances when the team might refer members for withdrawal management and gave examples of substances likely to require that support. One staff also cited a conversation with	• Provide ongoing guidance to staff in the identified co-occurring treatment approach, IDDT. This may help the staff to provide consistent service if SASs transition off the team. Staff may benefit from additional training in trauma informed care. • Ensure member treatment plans identify member goals and individualized needs. Seek compromise with members to address substance use planning on their service plans. Ensure members have current service plans that reflect their status and goals. • Evaluate the benefit of offering co-occurring treatment groups specifically for members with co-occurring diagnoses.

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			the team Psychiatrist regarding the topic of withdrawal management. It was reported that the Psychiatrist said that consideration should be made for each individual's history of withdrawal, substance used, and level of use before recommending medical withdrawal management. A staff was uncertain if the team uses medication-assisted treatment (MAT). Based on records, some applicable members' service plans identify the plan and frequency for individual treatment. Service plans for some applicable members did not clearly identify a plan to address substance use. Current treatment plans were not located for three applicable members.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff reported that an employee on the team has direct lived experience of psychiatric recovery. A member said that they believe there are staff on the team with personal lived experience of psychiatric recovery. Members said that no current staff has disclosed their direct lived experience of psychiatric recovery.	• Sharing stories of recovery by staff with lived experience can offer members hope. Consider sharing these stories, when appropriate, with members.
Total Score:		**4.25**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	4
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	5
9. Substance Abuse Specialist on Team	1-5	4
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	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	4

	Rating Range	Score (1-5)
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	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	4
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.25**	
Highest Possible Score	**5**	