

ASSERTIVE COMMUNITY TREATMENT (ACT) FIDELITY REPORT

Date: March 2, 2018

To: Samuel Oghenejabor, ACT Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On February 6-7, 2018, T.J. Eggsware and Georgia Harris completed a review of the Terros 23rd Avenue Recovery Center Assertive Community Treatment (ACT) Team One. 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 Maricopa County.

Terros offers services that include: primary care, outpatient, residential, substance use treatment, crisis, recovery and mental health services. The agency operates multiple adult outpatient clinics and four ACT teams, two of which are located at the 23rd Avenue Recovery Center (formerly the Townley Clinic). This review will focus on the 23rd Avenue Recovery Center ACT Team One.

In member records, the individuals served through the agency are referred to as *patient*, but usually by their first names. 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 ACT team meeting on February 6, 2018;
- Interview with the team Clinical Coordinator (i.e., Team Leader);
- Group interview with two members receiving ACT services;
- Individual interviews with a Substance Abuse Specialist (SAS), Independent Living Skills (ILS) Specialist and ACT Specialist;
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of team documents and resources, including: eight-week outreach tracking, Mercy Maricopa Integrated Care (MMIC) *ACT Eligibility Screening Tool* and *Assertive Community Treatment (ACT) Operational Manual*, *ACT Morning Meeting Log*, resumes for the SAS and Employment Specialist (ES), group sign-in sheets, and staff contact list.

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:

- The team meets at least four times a week to discuss and plan services delivered to members.
- At the time of the review, the team is of sufficient size to provide coverage to the 99 members; additionally, some ACT specialists and medical staff are scheduled to work weekend shifts.
- The ACT team has two Nurses. Interviews and the records reviewed suggest that both Nurses provide clinic and community based services to members.
- The team maintains low admission and closure rates. Based on staff interview and data provided, less than six members per month were added to the team in the most recent six months, and in the prior year, no members were closed due to refusal or terminating services, moving from the geographic area with or without referral, or due to the team determining the member could not be served. Less than five members graduated off the team in the year prior to review, and it appears members achieve treatment goals at their own pace without external pressures on the team to graduate members.

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

- Evaluate precipitating factors affecting team involvement in member psychiatric hospital admissions. The ACT team should be directly involved with member psychiatric hospital admissions, and this review reflected staff participation in just six of the last ten admissions.
- Develop strategies to increase face-to-face contacts with the goal that at least 80% of ACT services occur in the community where staff can directly assess, monitor progress, model behaviors and assist members to use resources in natural, non-clinical settings. Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts.
- Proactively engage natural supports, on an average of four times monthly, as partners in supporting members' recovery goals. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports.
- Provide training to staff on an integrated approach to substance use treatment, including review of stage-wise treatment and associated interventions; how to develop treatment plans based on the member's perspective and incorporating co-occurring treatment language; and, strategies to engage members in individual and/or group treatment.
- There appear to be barriers in team communication and sharing of information related to member statuses. Though the team is actively rotating their visitation schedules, some staff are unfamiliar with the statuses of the members (e.g., residences, active natural supports), as well as member roster and caseload changes. All ACT staff should become familiar with the entire team of members, so they can provide relevant services. When possible, solicit input from ACT staff on strategies to organize the team and adhere to the SAMHSA ACT model. Additionally, consider updating the agency website to outline ACT services offered, referral contact information, etc.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	Excluding the ACT Psychiatrist, the member to staff caseload ratio was about 11:1 for the 99 member program.	
H2	Team Approach	1 – 5 5	A review of ten electronic member records found that for the period under review, 90% of members saw more than one staff person in two weeks. Members interviewed reported that they had contact with multiple staff in the prior week. Staff stated they carry caseloads but also reported they serve the entire team. However, when responding to certain interview questions some referenced their specific caseloads or seemed uncertain about member statuses across the team.	<ul style="list-style-type: none"> All ACT staff should become familiar with the entire team of members, so they can provide relevant services.
H3	Program Meeting	1 – 5 5	Staff reported the team is scheduled to meet daily Monday through Friday. Staff schedules include coverage for weekend hours, so not all staff works each weekday. The Monday meeting is small or may not occur, but staff reported that the full team meets Wednesday and Thursday; one Nurse does not work Tuesdays, but remaining staff will still meet as a group.	<ul style="list-style-type: none"> Explore how the current meeting schedule and/or structure may be impacting the staff's ability to be fully informed of member statuses.
H4	Practicing ACT Leader	1 – 5 3	The CC reported he spends close to 65% of his time providing direct services; this includes completing home visits, weekly visits with hospitalized members, and assisting members with hospital discharges. In ten member records reviewed the CC documented a total of eight office-based contacts with members, and no community-based services. A productivity report for a recent month was provided and the CC spent under 26 hours providing direct services for the month; this did include some community-based services. The report reflected services in quarter	<ul style="list-style-type: none"> Optimally, CC's delivery of direct services to members should account for at least 50% of his overall time and should be documented in the members' records. Evaluate tracking mechanisms to ensure all member service encounters are documented accurately.

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			hour increments, but based on records reviewed some notes were less than 15 minutes. As a result, it appears the CC spent less than 16% of his time providing direct services.	
H5	Continuity of Staffing	1 – 5 3	Based on data provided, 13 staff left the team in the most recent two-year period, a turnover rate of 54%. Over that time two CCs, two Peer Support Specialists (PSS), two Rehabilitation Specialists (RS), two ESs and four Nurses left the team. Staff reported that temporary staff filled positions in the last two years but not the last year; another staff reported they were unaware of temporary coverage.	<ul style="list-style-type: none"> When necessary, examine employees' motives for resignation, and attempt to identify causes for employee turnover. Optimally, turnover should be no greater than 20% for any two year period.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 87% of staff capacity over the past year, with 19 total vacancies including one staff on leave (starting late November 2017) who did not return to the team.	<ul style="list-style-type: none"> Continue efforts to retain qualified staff.
H7	Psychiatrist on Team	1 – 5 4	Staff reported the Psychiatrist attends team meetings intermittently, but at least one day per week, and rarely meets with members from other teams. Staff reported the Psychiatrist provides community-based services, but no examples were found in ten member records reviewed. Members reported they meet with the Psychiatrist about monthly, consistent with the documented frequency of contact for most members in ten records reviewed. The Psychiatrist is the lead Psychiatrist for the clinic, and spends time on other administrative tasks or meetings, but staff seemed uncertain the time those tasks entail.	<ul style="list-style-type: none"> Monitor time spent with lead tasks to assure 40 hours is spent serving the ACT team.
H8	Nurse on Team	1 – 5 5	The team is staffed with two Nurses who have no other administrative duties; they work nearly exclusively with the members on the ACT team. It was reported the ACT Nurses provide services to one to two members per week from the other ACT	

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			team at the clinic. The Nurses work four, ten-hour days with two days of overlapping coverage; one works Monday through Thursday and the other Wednesday through Saturday. The Nurses attend the team program meeting when scheduled to work unless member emergencies arise. Staff reported the Nurses provide community-based services and three examples were found over a month period in ten member records reviewed.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The team is staffed with one SAS who is a Licensed Associate Counselor (LAC) and has filled the role since April 2017. Based on the SASs resume, her prior experience includes nearly two years providing substance use treatment in addition to two years employment at a detoxification facility. Staff reported that ACT Team Two and Supportive members may attend the co-occurring treatment group facilitated by the ACT Team One SAS.	<ul style="list-style-type: none"> Hire a second SAS and ensure SASs primarily provide services to members assigned to the team. Time providing services to members on other teams is factored when assessing whether specialists are fully available staff.
H10	Vocational Specialist on Team	1 – 5 1	The ES position was filled February 5, 2018 after being vacant since December 2017. A resume for the ES was provided. There was no evidence the staff had training or experience in vocational services related to assisting SMI members to obtain employment in competitive settings. The RS position was vacant at the time of the program review; this was slated to be filled February 12, 2018.	<ul style="list-style-type: none"> Provide ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid members to obtain competitive positions.
H11	Program Size	1 – 5 5	At the time of the review the ACT team is of sufficient size to provide coverage, with 10 staff, including: Psychiatrist, two Nurses, CC, ACT Specialist, ILS Specialist, Housing Specialist (HS), PSS, SAS and ES.	
O1	Explicit Admission Criteria	1 – 5 5	The team follows the ACT admission criteria, as outlined by the Regional Behavioral Health Authority (RBHA). The CC reported that the team	

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			uses the MMIC <i>ACT Eligibility Screening Tool</i> to screen potential new members. The CC conducts the screenings, reviews the information with the team, and the Psychiatrist makes the ultimate determination. Referrals originate from less intensive teams at the clinic (i.e., Supportive) or other providers. Some members (e.g. who are inpatient) are streamed through the RBHA, and some providers elect to coordinate referrals through the RBHA. Staff reported no organizational pressure in the last year to admit members whom ACT staff did not feel met ACT admission criteria.	
O2	Intake Rate	1 – 5 5	The ACT team admission was less than six members per month during the six months prior to review. Four members joined the team in January 2018, one during the months of October and November 2017, and zero during the months of August – September and December 2017.	
O3	Full Responsibility for Treatment Services	1 – 5 4	<p>The team provides case management, psychiatric care/medication monitoring, most substance use treatment, and counseling. One member attends substance use treatment outside of the ACT team. The team does not refer out for counseling; the SAS is a LAC and provides counseling to ten or fewer members.</p> <p>Staff reported seven to nine members are in staffed residences or treatment settings. In addition, during the meeting observed, the team discussed a member in residential treatment who the team was recommending step-down to a lower intensity of residential treatment. It was reported that the member wanted to live independently, but staff seemed to focus on step-down.</p>	<ul style="list-style-type: none"> • Provide ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid members to obtain competitive positions. Focus areas include: job development in the community, aligning the job search with member goals, disclosure, and follow-along supports. Engage and educate members about how the team can directly assist them, and update ACT staff on member statuses. • Work with members who reside in staffed residences to determine if other options are available where they can be supported fully by ACT staff. As the designated housing service provider, ACT staff should

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			Due to turnover at the RS and ES positions, it is not clear if supportive employment services were available. Staff referenced members who received support or worked at other agencies, but did not know the status of employment support services provided, if any.	assume full responsibility for supportive housing services, including helping members find housing in integrated community settings and support to retain housing.
O4	Responsibility for Crisis Services	1 – 5 4	The ACT team reports that they have full responsibility for crisis services. On-call and backup coverage is rotated weekly and some staff work weekend hours. Staff reported all ACT members are given a printed list of numbers that includes staff contacts by name and position, the ACT team on-call, team back-up on-call, the Warm Line and the Crisis Line. One staff reported that most members call the team directly and estimated in the prior month less than 5% of crisis calls were routed through the crisis line to the team on-call. However, one staff documented in multiple member records that the members were aware of crisis services with the Urgent Psychiatric Care Center (UPC) and Warm Line for emergent needs; it was not clear if members were regularly encouraged to first contact ACT on-call staff. Based on review of recent hospital admissions, one member was brought to the hospital by a crisis team.	<ul style="list-style-type: none"> Continue to educate members and their supports on the role of the ACT team in crisis services. Consider providing members with team contact information in an even more portable/accessible way; some teams provide members with a team business card that includes the on-call number and phone numbers for all specialists (excluding the Psychiatrist and Nurses).
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported the team follows the RBHA's <i>Assertive Community Treatment (ACT) Operational Manual</i> hospitalization protocol. During business hours, members are transported to the clinic to meet with the Psychiatrist and/or Nurse, or staff contacts emergency services to request police assistance if the situation is deemed dangerous. After hours, the on-call assists with admissions if hospitalization is needed, transporting and staying	<ul style="list-style-type: none"> Optimally, the ACT team is involved in all decisions to hospitalize ACT members. Make certain all staff is informed about and follows the protocol. Work to resolve barriers to team involvement in hospitalizations. For example, develop plans with members in advance, especially if they have a history of

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			<p>with members until admitted. Staff reported they coordinate with inpatient Social Workers, and doctor-to-doctor contact with the team Psychiatrist occurs if requested by the hospital. Also, staff visit members within 24 hours of notification of admission and every 72 hours thereafter.</p> <p>Based on review with the CC, the team was involved in six of the last ten psychiatric hospital admissions. In four situations, the team was informed after the admission: one member self-admitted, one member was assisted by family, one member was admitted following an incarceration, and one member was brought to the hospital by a crisis team. Additionally, in one record reviewed for a member not included in the ten most recent hospital admissions, it was documented that a member was transported by ACT staff to the hospital for medical clearance prior to psychiatric treatment and hospitalization. There was no documented team follow-up, service, coordination or contact with the member or inpatient staff. Six days later the team was contacted and informed the member was ready for discharge.</p>	<p>admitting without informing the team.</p> <ul style="list-style-type: none"> • Discuss with members and identified supports (natural, formal, etc.) the pros and cons of involving the team in issues that may lead to hospitalization. Orient them to how the team can support members in the community to avert, or to assist in a hospital admission, should the need arise.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	<p>Staff reported they participate in discharge planning and pick up members at discharge. Post-discharge, members meet with the team Psychiatrist and Nurse within 72 hours, and staff contact members for five days. Day one is a home visit, and in the subsequent days there must be one other face-to-face; the remaining days can be face-to-face or phone contact. The CC reported the team was involved in the ten most recent discharges. However, one staff reported that one hospital occasionally discharges members with bus</p>	<ul style="list-style-type: none"> • Track discharge planning and monitor follow-up services and staff responsible for implementation and documentation. • Coordinate with inpatient staff, members, and their supports (both informal/natural and formal) to reinforce the benefits of including the team in hospital discharges.

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			passes and does not inform the team, accounting for an estimated two of the last ten member discharges. In one record, referenced in this report previously related to hospital admissions, the team was informed by inpatient staff that a member was ready for discharge, and one staff documented an outreach home visit on the same date. There was no documented team contact or coordination regarding that discharge in the record reviewed, nor was there documentation of five-day follow-up or indication the member met with the Psychiatrist or Nurse. In another record reviewed, it was documented that the member was out of state and the member's natural support informed the team the member was inpatient, but there was no evidence of coordination.	
O7	Time-unlimited Services	1 – 5 5	Per staff report, four members graduated from ACT in the 12 months prior to review. The CC did not project any members for graduation in the next 12 months and reported the team was not working with any members to consider step-down. The CC reported the team does not follow a standard transition plan.	<ul style="list-style-type: none"> Develop a transition plan for when members are showing signs of decreasing their level of care. Document the transition steps (e.g., in member service plans) when supporting member graduation so the member and all staff have a shared understanding of the process.
S1	Community-based Services	1 – 5 2	Staff estimated 60% or nearly all of their time is spent in the community. The report was higher than the results of ten records reviewed that found a median of 38% of community-based contact with members. Some members were encouraged to attend clinic-based groups. One staff reported that a recent priority for staff to enter same-day notes resulted in more time spent in the office. Members interviewed reported that they had more frequent contact with staff at the clinic. In some cases, when members visited the clinic, they had contact with multiple staff, some	<ul style="list-style-type: none"> When engaging members to participate in meaningful community activities, first explore activities in their community. Optimally, the majority of ACT services (at least 80%) should occur in the community where challenges are more likely to occur, where staff can directly assess, monitor progress, model behaviors, assist members to use resources in a natural, non-clinical setting, and where staff can support them to create and connect with natural supports.

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			only brief check-ins.	
S2	No Drop-out Policy	1 – 5 5	Based on staff report, in the prior year no members closed due to refusing services, could not be located, team determined they could not be served, left the geographic area with or without a referral, and no members transitioned off the team to a <i>Navigator</i> status. Two members transferred to other ACT teams.	
S3	Assertive Engagement Mechanisms	1 – 5 4	<p>Staff reported they follow an eight week outreach process (which is often extended) and the RBHA <i>Assertive Community Treatment (ACT) Operational Manual</i> if members are not in contact with the team. Staff reported they coordinate with formal supports (e.g., probation officers, payees) and search for disengaged members at shelters. Staff reported that the team has coordinated with some payees to have members' weekly checks sent to the clinic; members must then visit the clinic to pick up their check.</p> <p>One member was out of state, and the member's natural support contacted staff twice over a month timeframe to report the member was inpatient, but there was no evidence of coordination or subsequent outreach. In five records reviewed, there was at least one instance for each member where a week or more lapsed with no team documented outreach or engagement.</p>	<ul style="list-style-type: none"> • Make certain staff is familiar with the eight outreach expectations outlined in the RBHA <i>ACT Manual</i>, where it prompts staff to conduct at least four weekly outreach attempts, of which at least two must be in the community. • Track last contact with members, as well as outreach and engagement efforts. Identify specific plans for contact, responsible staff, and report back to the team during the program meeting. • Evaluate the benefit to members of having checks mailed from payees to the clinic; confirm with members that this process is in place for their convenience rather than as a reason to require members to visit the treatment setting to make contact with staff. To the extent possible, engage members in their communities and where they receive support.
S4	Intensity of Services	1 – 5 3	The median intensity of face-to-face service time spent per member was 63 minutes weekly, based on review of ten member records. Two of the ten members received more than 120 minutes average weekly service time. One staff indicated there was a prioritization of certain elements of	<ul style="list-style-type: none"> • The ACT team should provide members an average of two hours of face-to-face contact weekly. Intensity may vary based on where each member is in their recovery, but an average of two hours across the entire team should be the goal.

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			services (e.g., frequency of contact or documentation) over other aspects (e.g., intensity of services).	<ul style="list-style-type: none"> Work with staff to identify and resolve barriers to increasing the average intensity of services to members, and clarify this goal within the scope of ACT staff services.
S5	Frequency of Contact	1 – 5 3	The median weekly face-to-face contact for ten members was just under 2.9, based on review of records. Over a month timeframe, three of ten members received an average of four or more contacts per week, and seven members received an average of three or less contacts per week.	<ul style="list-style-type: none"> Increase the frequency of contact with members by ACT staff, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support member goals. Work with staff to identify and resolve barriers to increasing the frequency of contact with members.
S6	Work with Support System	1 – 5 2	Two staff estimated about 70% of members have natural (i.e., informal) supports and one staff reported the team averaged weekly contact. One staff gave a report on their direct caseload of 12 – 15 members; about 50% of them had informal supports and the team made contact with them about twice a month. Based on the ten member records reviewed, the ACT team has infrequent contact with informal supports, .5 per month on average over the course of a month. Few examples of informal support contacts were documented. Contact was usually initiated by the natural support requesting assistance or informing the team of the member's status. Staff infrequently referenced recent contact with informal supports during the program meeting observed; recent contact or plans to contact informal support was discussed for eight members.	<ul style="list-style-type: none"> Encourage members to identify their supports and discuss with them the benefits of involvement in their treatment. The ACT team should have four or more contacts documented per month with informal supports, for each member with a support system. The team may benefit from further training and guidance, through the agency and/or system partners, on strategies to engage natural supports. Monitor that staff accurately document contacts with informal/natural supports in the member records.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported about 12 of the 48 members with a co-occurring diagnosis engages in structured individualized treatment. Weekly sessions are scheduled, but not all members participate at that frequency. In a recent seven day period, the SAS	<ul style="list-style-type: none"> Provide ongoing supervision and guidance to support the SAS's efforts to provide individual substance abuse treatment.

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			reported she provided about seven individual sessions. Sessions range from 20 minutes to an hour. The SAS reported she sporadically makes contact with the 36 members not in regular individual treatment, for about 10 to 15 minutes in duration. During the meeting observed, the SAS referenced individual treatment for eight members. The SAS provided a recent month calendar that showed individual sessions were scheduled, but the reviewers were unable to verify individual sessions in records reviewed. Only two of the ten randomly selected records were for members with a co-occurring diagnosis. There was at least one reference per record of contact by the SAS when members were in the office, and the assessed stage of change was documented.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The SAS on the team facilitates one weekly co-occurring treatment group at the clinic, and reported about two to three ACT Team One members attend. No evidence of ACT Team One co-occurring treatment group participation was documented in the two applicable records reviewed. Sign-in sheets for a recent four week period showed five ACT Team One members with a substance use diagnosis attended group at least once, which is about 10% of members. There were names on the sign-in sheet that were not found on the ACT Team One member roster. Staff reported at least one Supportive service level member attends the ACT Team One SAS group. It appears members may attend other substance use treatment groups at the clinic, but staff interviewed seemed uncertain regarding details of those groups or member participation.	<ul style="list-style-type: none"> Engage members diagnosed with a co-occurring disorder to participate in treatment groups based on their stage of treatment. Optimally, at least 50% of dually-diagnosed members should attend at least one treatment group monthly. Consider expanding the number of co-occurring groups offered to accommodate members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). Ensure co-occurring treatment groups are based on an evidence-based approach. See also recommendations for S9, Co-occurring Disorders (Dual Disorders) Model. See also, recommendation for H9, Substance Abuse Specialist on Team.
S9	Co-occurring	1 – 5	The team appears to rely primarily on the SAS to	<ul style="list-style-type: none"> Provide training to all staff on integrated

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	Disorders (Dual Disorders) Model	3	<p>address substance use issues with members. Staff reported the team uses harm reduction tactics and cited an example of a member who reduced alcohol use with team support.</p> <p>Staff reported the team utilizes Integrated Dual Disorder Treatment (IDDT), but they were unsure if the full team was trained in IDDT. The SAS reported she draws from prior experience, using cognitive behavioral techniques, and internet resources (e.g., SAMHSA). It is not clear if the resources are available to other staff on the team, and resources utilized were not available to the reviewers. Staff reported they were familiar with the stages of change. However, in a record reviewed it was documented a member was sober but the assessed stage of change was preparation/ action. During the program meeting observed, staff occasionally referenced members' stages of change.</p> <p>Based on records reviewed, there was no evidence of stage-wise treatment interventions incorporated in applicable service plans to support member goals. Service plans seemed to focus on symptoms of mental illness and a general list of services available to members by staff position such as Psychiatrist, Nurse and Case Management, but not SAS. The team does not actively engage members to attend Alcoholics Anonymous (AA), nor do they appear to support members if they so choose to participate in AA meetings. Staff cited an example of a member who expressed interest in AA and was directed to conduct an internet search for a meeting option. Staff reported the team may refer members for detoxification based</p>	<p>substance use treatment, including a stage-wise approach (i.e., engagement, persuasion, active treatment, and relapse prevention). Align staff activities and interventions to each member's stage of treatment. Having a common treatment approach should benefit the members served.</p> <ul style="list-style-type: none"> • Make available resources or materials utilized by the SAS to other staff to reference. • The team would benefit from review of how to incorporate interventions in treatment plans and notes. • If may be beneficial for staff to maintain a list of self-help groups that are known to be more accepting to SMI members. When possible, attend with members until they feel comfortable.

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			on member request or if a member is potentially a harm to self and/or others. It was not clear to what extent the team distinguishes when detoxification is medically indicated.	
S10	Role of Consumers on Treatment Team	1 – 5 4	The ACT team has a Peer Support Specialist, but staff interviewed were uncertain whether the staff has lived experience. Members interviewed were not familiar with the PSS staff's role on the team.	<ul style="list-style-type: none"> Confirm member perspective is represented on the team. Educate staff and members about the role of staff on the team who have disclosed lived experience.
Total Score:		3.71		

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	3
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	1
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	4
5. Responsibility for Hospital Admissions	1-5	3

6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
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	4
Total Score		3.71
Highest Possible Score		5