ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: September 15, 2017

To: Frank Scarpati, Chief Executive Officer
David Garrett, Clinical Coordinator

From: Karen Voyer-Caravona, MA, LMSW
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AHCCCS Fidelity Reviewers

Method

On August 15 -16, 2017, Karen Voyer-Caravona and Hannah Koch completed a review of the Community Bridges, Inc. 99th Ave Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

The 99th Ave ACT team is located at 842 N. 99th Ave in Avondale, Arizona. CBI is a peer-driven organization that demonstrates a significant commitment to hiring individuals with the lived experience of recovery from behavioral health challenges. The agency houses two ACT teams at the 99th Ave location, as well as a primary care provider (PCP), along with three Forensic ACT (F-ACT) teams at a site in downtown Phoenix. The ACT team, which began operating in August 2015, was previously reviewed as the Maryvale ACT team under the management of Chicanos Por La Causa (CPLC). The team transferred to CBI management in April 2017. Forty-five (45) of the former Maryvale members transitioned to CBI, and no information was provided or available regarding the disposition of the members who did not transition. None of the previous CPLC Maryvale ACT staff followed the team. New staff were hired to serve those 45 members, with plans to fully staff the team as it reached capacity. At the time of the review, the team consisted of 60 members served by nine clinical staff including the Clinical Coordinator.

The individuals served through the agency are referred to as "clients" or "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 ACT team meeting;
- Group interview of six members receiving ACT services;
- Individual interview with Team Leader/Clinical Coordinator (CC);
- Individual interviews with the Substance Abuse Specialist (SAS), the Employment Specialist (ES), and the Independent Living Specialist (ILS);
- Charts were reviewed for ten members using the agency's electronic medical records system; and

- Review of administrative documentation provided (i.e. the CC encounter report, ACT Eligibility Screening Tool, CBI ACT99 Manual, staff training attendance logs for four specialists, staff resumes for four specialists, SAS encounter log, Integrated Dual Diagnosis Treatment (IDDT) group curriculum, and Substance Abuse Group sign in sheets).

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 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:

- Assertive engagement mechanisms: All staff interviewed thoroughly articulated the team's eight-week engagement strategy, which makes active use of street outreach strategies such as visiting known preferred member locations. In addition, the team uses legal mechanisms as a last resort or as required to maintain contact with members and keep them engaged in services.
- Explicit Admission Criteria: The ACT team follows the RBHA's ACT Eligibility Screening Tool. The CBI ACT99 Manual discusses the admission criteria and the screening protocol, and provides instructions for processing various types of referrals (i.e., new SMI, regular outpatient referrals and transfers, hospital, F-ACT).
- Individualized substance abuse treatment: ACT members diagnosed with a substance-use disorder receive an average of more than 24 minutes of formal structured individual substance abuse treatment per week. The reviewers found supporting evidence in the record review, and the SAS provided the reviewers with a log of individual substance abuse treatment contacts and time spent.

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

- Training and support in the ACT model: The team was able to verbalize some of the principles of the ACT model, but there was much evidence to support the need for additional training on effective implementation strategies for ACT services. Examples include increasing the direct service time of the Clinical Coordinator and increasing community contacts (see below).
- Continuity of staff: The present ACT team was unable to provide information about staff turnover prior to the transition from the previous provider agency to CBI. Because none of the previous staff transferred with members, the team has experienced a turnover rate of at least 100% in the last 24 months. However, in the four months since the transition no staff have left positions; the agency should focus efforts on continuing to retain existing staff and filling all vacancies.
- Psychiatrist on the team: The ACT team's Psychiatrist position was listed as vacant at the time of the review, although staff reported a candidate was hired to fill the position as of September 1, 2017. Since the inception of the team, psychiatric services have been covered by three agency Psychiatrists, including one who sees members via telemedicine. All the rotating Psychiatrists carry caseloads on other teams and none of them attend daily treatment team meetings. The agency should ensure that the ACT team has a full-time Psychiatrist whose time is fully dedicated to its members and who attends at least one team meeting per week.

- Intensity and frequency of community based service delivery: The team should increase the intensity and frequency of services so the average frequency of face-to-face contacts is four or more per week, and average intensity of service is two hours or more per week, per member. The team should work with members in the community, where challenges are the most likely to occur, allowing members to practice new behaviors and build skills such as problem solving, prioritizing conflicting wants and needs, and making contingency plans that can be monitored and supported. In natural community settings, staff can more effectively monitor progress and provide immediate feedback, guidance, and encouragement to members.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, 60 members were served by nine staff: a Clinical Coordinator (CC), two Nurses, a Substance Abuse Specialist (SAS), an Employment Specialist (ES), a Rehabilitation Specialist (RS), an Independent Living Specialist (ILS), a Housing Specialist (HS), and an ACT Specialist (AS). The member/staff ratio, excluding the rotating Psychiatrists, was calculated to be approximately 7:1.	• Ensure that member/staff ratios remain low as the team reaches capacity by hiring and maintaining full staffing.
H2	Team Approach	1 – 5 5	Members interviewed report they usually see between 2 – 3 different staff members each week. Per a review of ten randomly selected member records, 90% of members saw more than one staff person in a two week period. Staff interviewed said they have an assigned "paperwork" caseload but see everyone on the team through medication observations (*med obs*), on-call, and outreach that resemble a zoned system. Per staff report, members see multiple staff during the week and are sometimes assigned to staff members based on their specialties. In the member records, the reviewers found examples of the Program Assistant (PA) documenting encounters with members; however, these are not counted as part of the ACT staff contacts.	
H3	Program Meeting	1 – 5 5	Staff reported that the ACT team holds a program meeting five days a week, Monday through Friday, from 11AM – noon. General clinical staffings are held on Wednesdays directly after the program meeting. At the meeting observed by the reviewers, the CC provided most of the direction, although the Program Assistant (PA), who is a Behavioral Health Technician and a Certified Peer Support Specialist, appeared to have a significant	

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			role in managing the meeting and offering feedback. Each member was discussed, with a considerable amount of time spent reporting minutes of staff contact with members. When member issues came up that required extra time, staff requested those concerns be placed in the "parking lot" at the end of the meeting for further discussion. The reviewers observed, and staff interviewed confirmed, that none of the covering Psychiatrists attend the program meeting.	
H4	Practicing ACT Leader	1 – 5 3	While the CC estimated that he spends 50% of his time providing direct service to ACT members, data provided to the reviewers showed direct service time to be in the range of 15%. Record reviews confirmed the CC's service contacts come in the form of intakes, medication monitoring and observations, and face-to-face time servicing members with higher acuity needs. Members interviewed also described numerous, positive interactions with the CC.	• Monitor and track CC actual direct service time with members, with a goal of providing direct member services (preferably in the community) 50% of the time, to model interventions, and support the team specialists. • Where possible, streamline or eliminate CC administrative tasks not explicitly connected with his role as an ACT leader. • Ensure all direct member contacts are documented, in addition to outreach efforts.
H5	Continuity of Staffing	1 – 5 1	Staff said they had no data regarding staff turnover from the 20 months prior to the transition to CBI. However, since no previous staff followed the team to the new agency, the turnover rate was at least 100%.	• Continue efforts to hire and retain qualified staff. In order to effectively stabilize a team which has seen significant change, work with administration to thoroughly vet candidates to ensure they are the best fit for each position and the demands of an ACT level of service.
H6	Staff Capacity	1 – 5 4	No data was available from the previous provider agency for August 2016 through March 2017. The team provided data from April 2017 through July 2017, in which they reported a total of 16 vacancies for a staffing capacity of 75%. In the four months since the transition, the ACT team has	• See recommendation for Item H5, Continuity of Staffing.

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			maintained staffing and continues to fill existing vacancies.	
H7	Psychiatrist on Team	1 – 5 1	At the time of the review, the ACT Psychiatrist position was vacant, although staff said that one has been hired and will begin on September 1, 2017. Three agency Psychiatrists were covering services for the 60 members: two F-ACT Psychiatrists from the agency's downtown location (the Lodestar Day Resource Center), and one, located out-of-state, who sees members via telemedicine. The covering Psychiatrists do follow up after psychiatric appointments, sometimes conduct initial intakes with the CC, perform doc-to-doc meetings, and write amendment paperwork. Members are seen at the 99th Ave location, and all three carry separate caseloads from the 99th Ave team. Staff said that the Psychiatrists are available by cell phone and Link-Outlook Messenger, and that they usually communicate concerns through Nurse 1, which has worked very well. None of the Psychiatrists attend the program meetings.	• The ACT Psychiatrist is a key position on the team, often sharing final decision making duties with the CC, especially those with respect to psychiatric hospitalizations and transition to other levels of care. Due to the intensity of service provided to members who have been unsuccessful on traditional case management teams, it is critical that the ACT Psychiatrist be fully dedicated to the team, easily accessible to staff and members in crisis, and attend at least one program meeting a week. The team should hire and retain a full-time Psychiatrist.
H8	Nurse on Team	1 – 5 5	The ACT team has two Nurses. Staff said the Nurse1's role is to provide community services, coordinate medication, follow up with psychiatric appointments, and coordinate care with primary care providers (PCP). Nurse 1 also acts as a liaison between the covering Psychiatrists and the staff specialists. Nurse 2 joined the team at the end of July and is currently shadowing Nurse 1; it is expected that the Nurses will share their duties. Staff reported that the Nurses do not have any other responsibilities outside of the ACT team. Nurse 1 is accessible by phone; staff said they also have her personal cell number. The Nurses have on-call responsibilities, as well as after-hours	

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			availability in case of an emergency.	
H9	Substance Abuse Specialist on Team	1 – 5 4	The ACT team had one Substance Abuse Specialist (SAS) at the time of the review. The SAS is a Licensed Master of Social Work (LMSW) and has approximately ten years' experience providing individual and group therapy in a variety of treatment settings, including residential treatment, inpatient psychiatric, and community mental health. Per her resume, the SAS has five years of experience in substance abuse treatment, including with co-occurring diagnosed adults. The SAS receives clinical supervision through an agency Licensed Professional Counselor (LPC).	• Fill the second SAS position; continue to prioritize training and experience in providing individual and group substance abuse treatment.
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has two vocational specialists: an ES and an RS. The ES is a Certified Peer Support Specialist with five years' experience assisting adults with disabilities with employment goals. The majority of this experience appears to be in the area of noncompetitive work adjustment training, but the ES reports experience helping members create resumes, learn interviewing skills, and conduct job searches. Transcripts of the ES's recent online trainings include motivational interviewing and working with co-occurring diagnosed adults. Her last training in rehabilitative services was dated in 2015. The RS has a Bachelor of Arts in Human Services and an Associate Degree in Applied Behavioral Health Sciences. Most of her professional experience prior to her current position on the ACT team was working in case management with young adults/transitional age youth. Transcripts of recent online training via the RBHA include disability benefits (DB101) and rehabilitative services.	• Although the team is fully staffed with two vocational specialists, it appears that employment and rehabilitation-specific training, particularly to the RS, is required, in order to better provide the specialty service of assisting members in finding and maintaining competitive employment.

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H11	Program Size	1 – 5 4	At the time of the review the team had nine staff, with the most critical staff vacancy being that of the full-time ACT Psychiatrist. Staff expressed looking forward to the addition of a new full-time Psychiatrist beginning September 2017.	• The ACT team should have at least ten staff that can provide sufficient diversity of specialties to respond to member needs. Continue efforts to build the team with staff qualified for the ACT level of service.
O1	Explicit Admission Criteria	1 – 5 5	The ACT team follows the ACT Eligibility Screening Tool, which was developed by the RBHA. A copy of the screening tool was provided to the reviewers in the CBI ACT99 Manual, along with instructions for processing various types of referrals (i.e., new SMI, regular outpatient referrals and transfers, hospital, F-ACT). The CC conducts the screenings and staffs with whichever covering Psychiatrist is available. All staff interviewed were able to clearly describe the admission criteria. Staff reported that they experience no administrative pressure to accept members who do not fit the ACT criteria.	
O2	Intake Rate	1 – 5 5	The CBI agency took over operation of the ACT team in April 2017 with 45 members. The agency had no intake data for the first three of the six months (February, March, and April) prior to the review. However, data was provided for the last three: May (6), June (5), and July (6). Staff noted that the team had accepted two new members for the August at the time of the review. The ACT99 Manual states that the team should accept no more than 6 members per month once they reach 50% capacity.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management services, the ACT team is fully responsible for employment/rehabilitative services and substance abuse treatment. Staff reported that approximately 10 – 15 members have employment goals and are working with the ES; the ACT team does not use brokered services but does make	• The ACT team should ensure that all specialty services are provided within the team itself. Ongoing training supporting the ACT model and staff specialties may assist in this area. • Fill the ACT Psychiatrist position.

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			referrals to Vocational Rehabilitation for services such as funding of educational or career resources that ACT cannot provide. Staff said that all substance abuse treatment is conducted by the team, with the SAS providing individual and group substance abuse treatment. Staff said that all specialists are cross-trained to respond immediately to members presenting co-occurring issues. It was not clear to the reviewers that the ACT team provides individual counseling/psychotherapy. Staff interviewed said that, other than specialized treatments such as Eye Movement and Desensitization Reprocessing (EMDR) and Dialectical Behavioral Therapy (DBT), they are all capable of providing individual counseling/psychotherapy. However, they did not identify any staff member who had specific credentials to provide this service. The SAS, who is an LMSW, has experience in this area but was identified as only providing SA treatment. Her current caseload may preclude her from fulfilling the other psychotherapy needs of the entire team. The ACT team does not have full responsibility for housing services because approximately 37% of members reside in settings where they receive some level of staff support. However, the observation of the program meeting made it clear to the reviewers that the HS actively engages members to work on housing needs. Members interviewed could identify the HS by name and know the ACT team is available to assist them in this area.	

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			Psychiatric coverage for members is currently being provided by Psychiatrists within the broader agency, not within the ACT team. The ACT team does a good job coordinating with the covering Psychiatrists, but the doctors do not attend meetings and are not considered a fully integrated part of the team.	
O4	Responsibility for Crisis Services	1 – 5 4	Staff interviewed reported that the ACT team has daily 24-hour on-call services. The on-call phone rotates between staff members every 24 – 48 hours, with the shift occurring at the morning program meeting. Staff responds to all calls and has 15 minutes to return calls. In a crisis, the on-call provider staffs with the CC and also alerts the CC if the on-call staff needs to go into the community to meet the member. The CC is the backup on-call staff from Monday – Thursday. It was reported that all the ACT/F-ACT CCs from the CBI agency rotate the weekend backup on-call shift. Staff interviewed said that the agency has provided trainings in ASSIST and suicide prevention. Reviewers found evidence of de-escalation techniques discussed in documentation of clinical oversight groups. However, one staff interviewed reported the team needs more training in crisis management and response. The reviewers found several instances of members receiving crisis services, sometimes with staff assistance, at agency programs such as Central City Addiction Recovery Center (CCARC) and Community Psychiatric Emergency Center (CPEC).	• Although the agency has multiple crisis intervention programs/facilities, ensure that the ACT team staff are the primary provider of crisis services for members of this team.
O5	Responsibility for Hospital Admissions	1 – 5	The reviewers discussed the last ten psychiatric hospital admissions with the CC and found that the	• The team must continue to educate

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		3	ACT team was directly involved in 60% of those admissions. In several instances, members were transported to psychiatric facilities by outside entities such as the Department of Corrections or group home staff without notifying the team. In one case a member self-admitted.	members on the team's role in crisis and/or hospital admission. • Additionally, the team should evaluate their current crisis workflow to determine if members who are escalated are being met with appropriate de-escalation interventions by ACT staff.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	A review of the last ten psychiatric hospitalizations showed that the ACT team was directly involved in all ten discharges. Staff said that discharge planning begins as soon as members are admitted. Staff said they use a continuity of care checklist to ensure needs such as medical and psychiatric aftercare, housing, and necessary appointments are in place for discharge. Staff said that they coordinate with the hospital social worker and attend discharge staffings. The covering Psychiatrist holds a "doc to doc" meeting with the hospital Psychiatrist. Unless other arrangements are made, an ACT staff will pick the member up at the hospital, help them get their medication, take them shopping for groceries or other necessities, and take them to their identified residence. Staff also ensure that the member is seen in person with the covering Psychiatrist within 72 hours of discharge, as well as follow the five-day face to face contact protocol.	
O7	Time-unlimited Services	1 – 5 4	The agency could not provide complete data for the last 12 months. Since assuming responsibility for the team in April, however, no members have graduated from the team. Staff interviewed said that up to ten members might graduate in the next 12 months, with three to four members definitively graduating to a supportive team in that time. Staff said that graduation is considered	• ACT services are designed to be long-term, time unlimited for those individuals who have been unsuccessful on traditional case management programs that do not provide intensity and frequency of support. A graduation rate higher than 5% may indicate that some members may have been inappropriately referred for and

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			when members express an interest in doing so and are using services less often.	admitted to ACT services. • ACT teams should carefully assess the likelihood of potentially graduating members maintaining the same level of functioning on a supportive or connective team once access to the intensive, individualized and community-based supports are withdrawn.
S1	Community-based Services	1 – 5 2	Staff interviewed estimated that they spent 80% of their time delivering services in community-based settings. However, a review of ten randomly selected member records found that services occurred in the community 29% of the time. Over half of the records reviewed showed five or fewer total face-to-face contacts for the period under review, possibly indicating that some contacts are not being documented on a timely basis.	• Eighty percent (80%) of staff face-to-face contacts with members should occur in the community, where challenges are most likely to occur and learning new skills and behaviors is most effective. • The CC should periodically review and monitor member records to ensure the appropriate level of community-based contacts. The CC should mentor and coach staff who appear to have difficulty engaging members the community. • Identify and find solutions to any barriers to timely entry of documentation into the member record. If not already in place, consider technological solutions (i.e. mobile dictation apps).
S2	No Drop-out Policy	1 – 5 5	Forty five (45) members transferred from the previous provider clinic; the staff did not have any information regarding other members who did not transfer, and that is not factored into the score. Of the members who did transition to CBI, one left the team to join family out-of-state and declined a referral or assistance setting up services. Staff said this occurred shortly after the transition from the previous provider, before the staff had an opportunity to establish rapport. Staff said they	• ACT staff should continue its present focus on building trust and rapport with members that supports engagement with the team toward the realization of individualized recovery goals. • Continue use of the eight week engagement strategy in order to keep members connected to crisis and recovery services.

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			are trying to locate two other members, who have not yet engaged with the team and are still on the eight-week outreach protocol.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff interviewed consistently described an eight-week engagement strategy, which includes four outreach attempts, and makes regular use of street outreach approaches such as visiting members' known locations and rotating staff to maximize opportunities for successful re-engagement. Staff contact natural supports when they have signed Release of Information forms (ROI), communicate and coordinate with shelter staff, and check with hospitals, morgues, and detention centers. When necessary, staff use legal mechanisms to maintain engagement such as contacting Probation Officers and filing petitions for court ordered treatment. Staff said that if any part of the eight-week outreach strategy is not carried out as scheduled, the strategy resets to week one. The 99th Ave ACT Manual states that members are not closed from the RBHA system but "transitioned over to a Navigator Level of Care."	
S4	Intensity of Services	1 – 5 2	Per the record review, the median duration of face-to-face contacts between staff and members was 27.5 minutes per week, with a range from 18.75 minutes to 131 minutes. Six of the ten member records reviewed showed 27.50 minutes or fewer minutes.	• ACT teams should provide an *average* of two hours or more of face-to-face services per week. This is based on all members across the team; some may need more and some less week to week based on their individual needs. • Work with staff to identify and resolve barriers in increasing the average intensity of services to members. Ensure all services are documented.

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S5	Frequency of Contact	1 – 5 2	Per the review of ten member records, median face-to-face contacts was 1.13 per week. The range of contacts was .75 to eight contacts per week. Six members had fewer than two contacts per week. The record averaging eight visits per week appeared to be primarily medication observations.	• Increase the frequency of meaningful face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support specific member goals. Work with staff to identify and resolve barriers to increasing the frequency of contact with members. Ensure all services are documented.
S6	Work with Support System	1 – 5 3	Staff reported that 40% of members (23) live with families and that staff have at least one contact with family each week. Other staff reported that at least 50% of members have a natural support system and that all receive at least one contact per month. Staff said outreach originated equally between staff and member supports. This level of contact with the support systems, however, was not evidenced in the program meeting attended by the reviewers or the record review. A review of ten member records showed 1.10 contacts with supports per month. Contacts made by the Program Assistant (PA) are not counted in this item. The nature of those contacts included information gathering for assessment purposes, treatment planning, coordination of care, and supports notifying staff of changes in presentation or crisis.	• Ensure ACT staff review with members the potential benefits of including their informal supports in treatment at some level. Discuss with members when and how they would want to involve their support system, such as when facing challenges, to celebrate success toward recovery, and to educate informal supports about ways to help with recovery goals. • Discuss identifying informal supports on a recurring basis. For example, review with members who are engaged in peer run programs whether they have established informal supports with others who also attend.
S7	Individualized Substance Abuse Treatment	1 – 5 5	Per data provided by the agency, 35 of the 60 members have a co-occurring disorder. The SAS reported that she has engaged about 28 in individual substance abuse treatment. Of those, 21 are seen for an average of 45 minutes each week in scheduled, formal individual substance abuse treatment; this averages across all COD	

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			diagnosed members as 27 minutes weekly. The reviewers found documentation supporting weekly individual substance abuse counseling psychotherapy in several member records, with time spent ranging from 25 to 75 minutes. Sessions took place both in the member homes and in the office. The records reviewed suggested that most SAS face-to-face contacts are spent providing individual and group substance abuse treatment.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 4	The SAS provides one co-occurring treatment group every Wednesday at 2 p.m. Per interview, the group follows the Integrated Dual Diagnosis Treatment (IDDT) model and uses the curriculum provided by the RBHA, a copy of which was shown to the reviewers. Group lasts approximately one hour with attendance ranging from five to ten members with a COD. The SAS reported that some members attend every week, and, for the last month, about 18 members attended at least one co-occurring group. The reviewers were provided with copies of group sign-in sheets. For a 30-day period prior to the review (July 11 – August 9, 2017), 37% (13) of members identified with a COD attended the COD group at least one time.	• Increase outreach efforts to encourage more member participation in co-occurring treatment, with a goal of at least 50% of COD members participating in group treatment on a regular basis. • Consider offering co-occurring groups on multiple times and days to provide options for members with different or inconsistent scheduling needs.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The ACT team appears to use a mixed model. Training records provided by the agency for four of the current ACT staff indicate that the agency has provided some training and supervision in the model. However, it is not clear that all staff have received training in co-occurring principles. Additionally, some staff joined the team with no previous experience in ACT or with the adult SMI population. Most staff described using a Stages of Change model and harm reduction approaches. Most were not familiar with the term *Stage-Wise*	• Ensure that all staff receive ongoing training in a stage-wise approach to treatment, as well as interventions that align with a member's stage of treatment. Staff may benefit from guidance on how to document the services reflecting the stage-wise approach. This may better equip all ACT staff to engage members in individual and group SA treatment through the team.

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			Treatment but recognized the concept of aligning member readiness with appropriate interventions designed to support movement to latter change stages. Staff could describe stage-wise approaches in general ways but did not offer specific examples. As noted previously in this report, the SAS has considerable experience in substance abuse treatment in a variety of treatment settings, including with the SMI adult population. RBHA training transcripts indicate that she had received trainings relevant to the co-occurring model. Staff said that the SAS is also responsible for cross training the other specialists in the IDDT approach and this occurs regularly in the program meetings. Staff said that they do not refer members to AA or NA but may provide them those and other self-help resources in the community upon request. All staff interviewed reported that abstinence is an ideal that remains unrealistic for many members, though some may identify abstinence as their recovery goal. Staff said that they refer members to detox when it is deemed medically necessary or when the member requests it. Also, evidence was found in some COD member records of staff offering agency detox programs.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Though the position of PSS is currently vacant on the ACT team, CBI is a peer driven agency that strives to staff the clinical team with individuals with the lived experience of recovery from mental illness and addictions. All staff interviewed identify as people with lived experience of behavioral health challenges and who use self-disclosure when appropriate to build the trust and rapport necessary for successful engagement with	• Hire or identify a dedicated PSS staff person for the ACT team.

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			members. Members interviewed discussed the value they place in working with staff who can relate to their experiences of distress, struggle, and stigma associated with disability.	
Total Score:		**3.75**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
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	1
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	1
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	4
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	3
4. Responsibility for Crisis Services	1-5	4
5. Responsibility for Hospital Admissions	1-5	3

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	4
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	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	5
8. Co-occurring Disorders Treatment Groups	1-5	4
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.75**	
Highest Possible Score	**5**	