**ASSERTIVE COMMUNITY TREATMENT (ACT)**
**FIDELITY REPORT**

Date: April 23, 2021

To: John Hogeboom, President/CEO
Christopher Michael Copolillo, Clinical Coordinator

From: Annette Robertson, LMSW
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AHCCCS Fidelity Reviewers

**Method**

On March 22 – 23, 2021, Annette Robertson and Karen Voyer-Caravona completed a review of one of Community Bridges, Incorporated Assertive Community Treatment (ACT) teams. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Community Bridges, Inc. (CBI) operates several locations throughout Arizona. Services include supportive housing, crisis stabilization, ACT, and integrated healthcare. The agency operates three ACT teams and three Forensic ACT (F-ACT) teams in the Central region of Arizona. This report will focus on the F-ACT 2 team located in South Phoenix.

Due to the COVID-19 public health emergency, it was determined that the record portion of the review should be documentation for a period prior to the public health emergency. Reference in this report to the member records reviewed and related documentation are for the period prior to the public health emergency. Due to the public health emergency, the review was conducted remotely, using video or phone contact to interview staff and members.

The individuals served through the agency are referred to as *members*.

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

- Observation via videoconference of an ACT team meeting.
- Individual interviews with the Clinical Coordinator, Substance Abuse Specialist (SAS), ACT Specialist (AS), and a Nurse.
- Individual phone interviews with three members receiving ACT services.
- Charts were reviewed for ten members using the agency's electronic medical records system.
- Review of documents including the *Mercy Care FACT Admission Criteria*, F-ACT II staff contact sheet, resumes and training records for

the Substance Abuse Specialist (SAS) and vocational staff, resources used by the SAS, and the SAS calendar for one month.

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

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

**Summary & Key Recommendations**

The agency demonstrated strengths in the following program areas:

- The team has two veteran Nurses that deliver most services in the community and view any chance for in-person contact with members and their supports as an opportunity to offer and provide assistance.
- Direct involvement in psychiatric hospital discharge coordination was complete in ten out of ten member hospitalizations.
- The team embraces the co-occurring disorders treatment model. Following a stage-wise approach to substance use treatment, the team documented and expressed the importance of the use of rapport building in early-stage engagement to meet basic and immediate needs, a range of harm reduction strategies, *Motivational Interviewing*, cognitive behavioral techniques, psychoeducation, and decisional balancing to name a few. Staff repeatedly described allowing members to choose their own path, and the value of walking along with members in their journey as a support, rather than a leader.
- The team is providing education, personal protective equipment, and assisting members in scheduling and arranging transport for vaccinations, with flexibility to take into consideration member preferences and the fluidity of those preferences.

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

- Staffing issues affect multiple items for this team. At the time of the review, vacant positions on the team included the Housing, Employment, and Peer Support Specialists, as well as a second Substance Abuse Specialist. Lack of adequate staffing potentially impacts: the CC's ability to provide direct services with a roster that requires close coordination with criminal justice partners; the team's ability to provide the full level of employment services for members with histories that may eliminate them from many employment opportunities; and staff that can assist members to obtain safe and affordable housing in the least restrictive environment possible for members that likely would be excluded from many traditional low income programs due to their criminal history. Additionally, with 59 members identified as having a co-occurring disorder, substance use treatment services are provided to the members most willing to engage. It is suggested the agency focus on vetting potential staff with experience working with members with a serious mental illness and providing them with supervision and support to deliver the intensive services of the evidence-based practice of ACT.

**ACT FIDELITY SCALE**

| Item # | Item | Rating | Rating Rationale | Recommendations |
|---|---|---|---|---|
| H1 | Small Caseload | 1 – 5<br><br>4 | At the time of the review, there were seven full time equivalent (FTE) staff on the team, excluding the Psychiatrist. It was reported that there were 96 members on the team, leaving a member to staff ratio of nearly 14:1. | • Agency leadership should prioritize filling open positions on the team to make certain a 10:1 member to staff ratio exists. Small caseload size ensures adequate intensity and individualization of services and minimizes the potential burden on staff. |
| H2 | Team Approach | 1 – 5<br><br>4 | Staff interviewed reported the team attempts to ensure that all members are seen by multiple staff each week. Interviewees said that staff are assigned daily to a region and are expected to make contact with members in that region. A review of ten randomly selected member records from a period prior to the public health emergency, showed that 80% of members met with more than one staff from the ACT team in a two-week period. Members interviewed reported that they may see one staff at their home a week, but if they go into the office, they may see several staff. | • Increase contact of diverse staff with members. Team staff are jointly responsible for making sure each client receives the services needed to support recovery from mental illness. Diversity of staff interaction with members allows the members access to unique perspectives and the expertise of staff. Because of the number of vacant positions, it may be especially important for this team as it likely would reduce the burden of responsibility of care on staff as well. |
| H3 | Program Meeting | 1 – 5<br><br>5 | Staff interviews indicate the ACT team meets five days a week, with the Psychiatrist in attendance at four of those. The longer Wednesday team meeting is used to discuss members with high acuity or risk issues. The Nurses and specialists work four ten-hour shifts and attend on days they are scheduled to work. The CC, program assistant, and Psychiatrist work Monday - Friday. During the meeting observed by reviewers, all members were reviewed. Staff made several comments on the majority of members relating to next/missed appointments, last contact, next planned contact by staff and activities planned, interests in | |

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| | | | employment or rehabilitation activities, natural support contacts, hospitalizations, coordination with probation and other agencies/programs, and stage of change, among others. | |
| H4 | Practicing ACT Leader | 1 – 5<br><br>3 | The CC estimated delivering in-person services to members 5% of the time and an additional 10% via telehealth. Per CC report, the number of vacant positions on the team has impacted CC provision of in-person services. Services listed as being provided included updating treatment plans, counseling services, medication education, pre-employment supports including resume building, as well as coordination of care with natural supports, probation, courts, and special assistance offices. During the morning meeting observed, the CC described contact with several members the day before and plans for contacts with several members in the community later that day. Reviewers were also informed that the CC assists with psychiatric hospital admissions and discharges. *The fidelity tool does not accommodate for telehealth services*. | • Optimally the CC should provide in-person services to members 50% or more of the time. ACT leaders who have direct clinical contact with members are better able to model appropriate clinical interventions and remain in touch with the members served by the team.<br>• The CC and the agency should identify any administrative functions not essential to the CC's time that could be performed by the program assistant or other administrative staff to free up time for direct member services. |
| H5 | Continuity of Staffing | 1 – 5<br><br>3 | Based on information provided, the team experienced turnover of 54% during the past two years. At least 13 staff left the team during this period. The Peer Support Specialist position had the highest turnover with four staff. The Housing, Employment, and ACT Specialist positions all had two staff leave in the two years reviewed. | • Examine employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention. ACT teams should strive for a turnover rate of less than 20%. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.<br>• The agency may want to consider identifying contributing factors to high staff turnover and working to find solutions. Consider anonymous employee satisfaction |

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| | | | | survey and exit interviews to gather and analyze feedback regarding why staff leave, as well as factors that promote retention. |
| H6 | Staff Capacity | 1 – 5<br><br>4 | In the past 12 months, the ACT team operated at approximately 88% of full staffing capacity. The Housing and the Peer Support Specialist positions were each vacant for five and six months, respectively. | • To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible. Timely filling of vacant positions helps to reduce potential burden on staff. |
| H7 | Psychiatrist on Team | 1 – 5<br><br>4 | The team has one full-time Psychiatrist that works Tuesday – Friday. The Psychiatrist attends program meetings daily, providing leadership, member advocacy, integrated care, and offers feedback to the team on member interactions. The Psychiatrist is available by phone, text, Microsoft teams, and email. More than one staff reported Psychiatrist availability after hours and weekends, yet one staff stated if the team is unable to reach the ACT psychiatrist, the agency has other prescribers on rotation for after-hours needs. The Psychiatrist diligently informs members about their right to judicial review when placed on or renewed for court ordered treatment. | • Increase the prescriber's time assigned to the F-ACT team. ACT teams with a 100-member roster should have one full time psychiatrist assigned to the team.<br>• Ensure all ACT staff are aware the Psychiatrist has after hours and weekends availability to ensure continuity of care of members. |
| H8 | Nurse on Team | 1 – 5<br><br>5 | The ACT team has two full time Nurses. Both work four 10-hour days and attend the program meeting on days they are scheduled to work. Staff reported they are accessible through messaging, phone, text, and email. Staff said they are accessible after hours and weekends and rotate that responsibility. The majority of nursing services are provided in-person in the community and include medication education/distribution/observation, delivering injections, accompany members to specialty appointments, and offering support to members and their natural supports. Staff reported that the | |

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| | | | Nurses provide education to the team on medications and new diagnoses. The Nurses provide telehealth services as well as services at the office, depending on member need. | |
| H9 | Substance Abuse Specialist on Team | 1 – 5<br><br>3 | The team has one SAS that has been in the role for more than three years to serve the members with a co-occurring diagnosis. The SAS is a Licensed Associate Counselor with a dual master's degree in Professional Counseling and Addiction Counseling. Training records provided indicate clinical supervision occurs twice monthly for an hour by a Licensed Professional Counselor in a small group setting. Topics identified included mindfulness, personal bias, building best care practices, benefits of engaging with natural supports, and the transtheoretical model of change. | • Fill the vacant SAS position. The team should have 2 FTE SASs. When screening potential candidates for the position, consider experience working with members with a co-occurring disorder and integrated care. The SAS should have the capability to cross train other ACT specialists in this area. |
| H10 | Vocational Specialist on Team | 1 – 5<br><br>3 | At the time of the review, the team had one vocational staff, the Rehabilitation Specialist (RS). The RS has more than a year of experience working on the ACT team. Training records provided showed few trainings related to the position. However, staff interviewed reported that the RS attends quarterly Vocational Services trainings offered by the RBHA, although participation was not documented in training records received. The Employment Specialist position was vacant at the time of the review. | • Hire a second Vocational Specialist (VS). Provide training and support to all VS staff in helping clients to find and keep jobs in integrated work settings. Optimally, training would include strategies for engaging clients to consider employment, job development, supporting individualized job search, and providing follow-along support.<br>• Ensure all training and supervision related to VS services is documented. |
| H11 | Program Size | 1 – 5<br><br>4 | The team has eight full time staff assigned to the team: Psychiatrist, CC, two Nurses, SAS, RS, ACT Specialist, and the Independent Living Specialist. | • Hire and maintain adequate staffing. A fully staffed team allows the team to consistently provide diverse coverage; allows staff to practice their specialties which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member. |

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| O1 | Explicit Admission Criteria | 1 – 5<br><br>5 | Based on interviews with staff, the team follows the F-ACT admission criteria developed by the Regional Behavioral Health Authority (RBHA). Initiated by courts, probation, jails, and prisons, referrals are sent to the RBHA and then forwarded to the team. Several staff on the team are able to conduct screenings of those referred to determine appropriateness. The team has continued to do screenings in person when the referring facility has allowed it, otherwise they are done by phone. After the screening is complete, the CC and Psychiatrist review the information and if appropriate, and the member agrees to the service, an intake appointment is scheduled with the Psychiatrist. Staff reported that referral recruitment has not been necessary during the past 12 months, and the CC denied pressure to accept inappropriate referrals. | |
| O2 | Intake Rate | 1 – 5<br><br>4 | The ACT team reports 14 admissions in the last six months. Data provided and reviewed with staff indicates the highest intake month was September 2020 when seven members were admitted to the team. | • Ideally, new intakes should not exceed six each month for a fully staffed team. Consider staffing capacity when admitting new members to the team to alleviate potential burden on staff. |
| O3 | Full Responsibility for Treatment Services | 1 – 5<br><br>4 | In addition to case management services, the team directly provides psychiatric services, substance use treatment, and psychotherapy/counseling services. Employment services are being provided by staff on the team covering the responsibilities of the vacant Employment Specialist position. Evidence was noted in records reviewed of the team delivering all of these services. Two members are receiving medicated assisted treatment through a provider outside the ACT team. During the meeting observed, at least two members were identified as receiving employment supports, three | • The team should assist members to find housing in the least restrictive environments, which can reduce the possibility for overlapping services with other housing providers. Assist members to explore low-income housing options to increase their housing choices. For members with histories that limit availability of housing options, consider legal measures to expunge their record.<br>• Ensure members are informed of and understand staff roles on the ACT team. |

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| | | | were identified as being scheduled for general counseling, and staff were planning to meet with many others to address substance use. Several members were identified with housing needs or the need for coordination relating to residential referrals. One member interviewed reported being engaged in counseling services with someone associated with the team but was unclear of the staff's role.<br><br>The team has at least seven members housed in settings where there are staff on site providing one-to-one services. At least one member was enrolled in an inpatient substance use program. Although there were varying reports from staff on the number of members reported to be living in half-way houses, that at a minimum have supervision, it appears there are at least four. Some of these programs assist members in finding employment to assist with rent and hold medications. Others mandate attendance in peer run support groups or religious services. At least one member is receiving housing support services through a supportive housing provider. Staff do provide housing support services as seen in one record reviewed. Multiple times, staff assisted a member in cleaning their apartment and discussed eviction prevention measures, including the importance of following a lease. | |
| O4 | Responsibility for Crisis Services | 1 – 5<br><br>5 | Per interviews with staff, the team provides services to members 24-hours seven days a week. The team provides after hours crisis services by rotating on-call responsibilities among specialists every 24-hours. Members are provided a document with staff roles and phone numbers, and | |

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| | | | the on-call number. Specialists provide support by phone and will confer with the CC when deciding to go into the community to offer in-person supportive services. The CC also serves as the back-up to the specialists. All members interviewed were aware of after hour supports being available through the team. | |
| O5 | Responsibility for Hospital Admissions | 1 – 5<br><br>4 | Per review with staff of the ten most recent psychiatric hospital admissions, the team directly supported 90% of members. One member admitted themselves after an incident at their housing situation. The member has since changed their living environment.<br><br>Staff reported that when members do present with a request for psychiatric hospitalization, the team will assess and offer an appointment with the Psychiatrist. If the recommendation is for inpatient treatment, the team will provide transportation. Some facilities do not allow staff inside because of the public health emergency, but the team reported doing their best to provide a warm hand-off. Staff will provide a medication log and information on how to contact the ACT team. Upon admission, the team will coordinate with the inpatient team to arrange for a doctor-to-doctor and nurse-to-nurse consultations, as well as providing on going coordination every 72 hours. | • Continue efforts to educate and build relationships with members and their supports on how the team can assist when a member feels they may need inpatient psychiatric stabilization. |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5<br><br>5 | The team begins discussing the discharge plan with the inpatient psychiatric team when members are initially admitted. Staff reported that when the date is determined, they will provide follow up appointments within 72 hours of discharge for the Psychiatrist, as well as arrange a primary care physician appointment within ten days. The team | • Continue to build relationships with inpatient staff and use resources available to advocate for member care. Some teams create business cards with team information that members can carry on their person to reference when interacting |

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| | | | will meet the member upon discharge to obtain paperwork, provide transportation, assist with getting medications, and provide a visit in the member's home as they transition back into the community. The team completes five days of in-person follow up care, supporting the member to attend scheduled appointments.<br><br>In records reviewed for one member, the team provided a doctor-to-doctor consultation, and the Nurse completed an in-person nurse-to-nurse meeting. During the program meeting observed, staff discussed difficulty coordinating member care and arranging a doctor-to-doctor appointment with a specific agency. | with other agencies/providers and expedite coordination of care. |
| O7 | Time-unlimited Services | 1 – 5<br><br>5 | Staff interviewed reported that the team expects to graduate 3 - 4% of members during the next 12 months. In the previous year, six members on the team graduated from ACT services. Staff reported that members lead these discussions and should be noted in their treatment plan. | |
| S1 | Community-based Services | 1 – 5<br><br>4 | Staff reported that approximately 60% of their in-person contacts with members occur in the community. Initially, during the public health emergency, staff were based from home, however, staff are now coming into the office and delivering services in the community as public health and agency protocols relax. Based on records reviewed for a period prior to the public health emergency, a median of 68% of services occurred in the community. The review revealed inconsistency in the team's approach to each member. For instance, two members received all ACT services in the community, while the three members with the | • Work to increase delivery of services to members in the community to 80% of the time. Continue efforts to engage with members in a manner that they feel most comfortable as public health protocols change. Continue efforts to educate and support members in taking measures to improve their outcomes and reach their goals at a pace they feel most comfortable. |

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| | | | lowest percentage of contact in the community were seen five days or less in that month period.<br><br>Staff reported that members are seen at the office without an appointment noting that it can be difficult to engage with some members and the team sees members presenting themselves at the office as an opportunity to provide services to meet the members' needs.<br><br>Staff reported that they educate members on the guidelines relating to the public health emergency and members have shown a willingness to comply with all safety measures. When in a member's home and others are present, staff will ask the others to either step into another room or wear a mask, and members have been supportive. One staff reported the team is assisting members to get scheduled for vaccinations, noting transportation for the appointments through member's insurance has been helpful. | |
| S2 | No Drop-out Policy | 1 – 5<br><br>5 | The ACT team rarely closes cases due to lack of contact or service refusal but instead seeks to work with members to address needs and service preferences. The team assists members in setting up services when they relocate and readmitted several members who briefly transitioned to Navigator status due to lack of contact. Three members could not be located and were moved to Navigator level of care. At least two members transferred to a lower level of care, preferring less intense case management services. Twelve members were closed after being incarcerated, four of whom have since returned to the team upon release. | |

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| S3 | Assertive Engagement Mechanisms | 1 – 5<br><br>4 | Staff reported following an eight-week outreach protocol when losing contact with a member. The team will reach out to criminal justice partners, payee services, as well as searching the local housing management system. There was evidence in records reviewed, from a period prior to the public health emergency, of assertive engagement strategies used by the team including street outreach by multiple staff and contact with natural supports. The team also discussed engagement strategies with difficult to engage and locate members. One note showed staff stressing importance of all specialists offering members support and recovery-oriented services. However, records also showed gaps in contact with members and/or lack of documentation of outreach efforts. | • If members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact, i.e., missed appointment. Discuss and track these efforts during the program meeting. Consider peer review of documentation to ensure outreach efforts are accurately included in member records. |
| S4 | Intensity of Services | 1 – 5<br><br>3 | Per a review of ten randomly selected member records, during a month period before to the public health emergency, the median amount of time the team spends in-person with members per week is 52 minutes. Only three records averaged at least 120 minutes of in-person services. One staff interviewed reported that members seem to be seeking less intensive contact from the team during the public health emergency. Two staff reported that the team is assisting members in scheduling vaccination appointments, recognizing that the isolative nature of the public health emergency has had negative implications for members. | • ACT teams should provide an average of two hours or more of face-to-face services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on their individual needs, recovery goals, and symptoms. Continue to consider member safety concerns during the public health emergency and providing education on steps they can take to reduce the risk of infection, including vaccination, wearing of masks, and social distancing. |
| S5 | Frequency of Contact | 1 – 5<br><br>3 | Staff reported that the agency reacted quickly to the public health emergency, providing personal protective equipment for staff and members, and utilizing telehealth services by phone and video, assessing which members had access to devices | • Increase the frequency of contact with members by ACT staff, to the extent possible, preferably averaging four or more in-person contacts a week per member across all members, with an emphasis on |

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| | | | with that capability. For members without devices with videoconferencing capability, and that were interested in receiving telehealth services, the agency provided tablets and phones with the application necessary to receive those services already uploaded. Staff provided assistance to the members in the use of the application. One staff reported services are more frequently delivered by phone during the public health emergency, stating that some members do not want physical contact by the team.<br>*The fidelity tool does not account for telehealth services.* | community-based services to support member goals. Members may have different needs/goals and frequency of contact should be determined by those needs and immediacy.<br>• Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to provide ongoing support. Improved outcomes are associated with frequent contact. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. |
| S6 | Work with Support System | 1 – 5<br><br>4 | Staff interviewed reported 20 – 30% of members have natural supports. Staff estimate most of those supports have weekly contact from the team, but those contacts may not always be documented in member records. Five out of ten records reviewed showed staff connecting with members' natural supports during a month period. One member interviewed stated that the team tends to call their natural support more often than themselves and that the support is comforted by the services the team provides. | • Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four per month for each member with a support system.<br>• Consider periodic peer review of documentation of natural support contact in member records to increase the team citing these interactions. |
| S7 | Individualized Substance Abuse Treatment | 1 – 5<br><br>4 | The team has 59 members on the roster identified as having a co-occurring diagnosis, however, only one staff is providing substance use treatment services. The SAS is offering and or delivering weekly individual substance use treatment services to 25 - 30 members of the team. The remaining members with a co-occurring diagnosis are reportedly engaged by more seasoned staff on the team. The team reports following the Integrated Dual Disorders Treatment model (IDDT), using | • Hire a second SAS. Provide adequate training and support to align with the stage wise treatment services already being provided on the team. |

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| | | | Cognitive Behavior Therapy, with a solution focused lens. More than half of the members with a co-occurring diagnosis are identified as being in the pre-contemplative/contemplative stages of change. The interactions described as being provided by the team are stage appropriate. Staff reported that they assist members in identifying their stage of change during individual sessions. Resources identified as being used include Hazelden's *Integrated Services for Substance Use and Mental Health Problems*. | |
| S8 | Co-occurring Disorder Treatment Groups | 1 – 5<br><br>2 | Staff reported that less than 10% of the members with a co-occurring disorder attend a substance use treatment group provided by the team monthly. One weekly group is offered and is led by the SAS, following the IDDT model. The resource identified as being used to facilitate the group is Dartmouth PRC/Hazelden's *IDDT Recovery Life Skills Program: A Group Approach to Relapse Prevention and Healthy Living*. The in-person group is open to members in all stages of change as well as members from other CBI ACT teams. Members do have the ability to attend via videoconference if that is their preference. | • All ACT staff should encourage members with a co-occurring diagnosis to participate in treatment groups based on their stage of change. Optimally, at least 50% of members diagnosed with a COD attend at least one treatment group monthly.<br>• When possible, provide a second group to members. Consider identifying one group for members in the pre-contemplative/contemplative stages. Often ACT teams identify these types of groups as a whole health group focusing on wellness and problem-solving around life issues. The second group could be more focused for members in the action/maintenance stages. |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 – 5<br><br>5 | Staff interviewed reported that they support the members in their identified goals. If a member's goal is harm reduction, they support the member in those efforts. If their goal is abstinence, then the team will support that. One staff described their role as being alongside the member supporting them in their journey wherever that may lead. Staff identified the importance of recognizing member's | • *System stakeholders may want to consider collaborating with the team/agency to identify factors and steps taken that have cultivated a team culture that has supports the co-occurring model into practice.* |

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| | | | right to self-determination, validating their feelings, supporting choices, and allowing them to come to their own decisions about their recovery. It was, however, documented in several member records that they were required to complete a urine drug screen and was included in one member's service plan. Staff reported engaging members to identify their *stage of change*, aligning interventions to match that stage. Staff assist and motivate members to move to the next stage, supporting them with harm reduction efforts, such as using substances via less hazardous/lethal means. In one record reviewed, a staff suggested a member consider reducing their use after being evicted due to frequency of disruptive guests and behaviors of the member towards neighbors. Another record documented staff encouraging a member that was panhandling to discreetly sip their alcoholic beverage to avoid legal entanglements.<br><br>Service plans reviewed for members with a co-occurring disorder identified behavioral health counseling as a tool to address objectives of increasing coping skills, discussing pros and cons of continued use, identifying triggers, creating an environment of recovery, and managing cravings. For members in the pre-contemplative stage, goals focused on immediate member needs relating to social determinants of health, i.e., seeking housing, securing food, physical health treatment.<br><br>Staff will refer members to the IDDT group provided by the team but will also support members if they seek extra support within their | |

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| | | | community to attend peer run groups. Staff have provided education to members on staying safe when meeting in groups regarding the public health emergency. If members request detoxification services, the team will refer them to those services.<br><br>During the program meeting observed, staff identified members stage of change, if they were scheduled for individual counseling, and if staff were planning to invite to the IDDT group. | |
| S10 | Role of Consumers on Treatment Team | 1 – 5<br><br>5 | Although at the time of the review the Peer Support Specialist position was vacant, there were several staff that identified as having lived psychiatric experience. Staff interviewed reported that it is not uncommon for staff to share their story of recovery with members, particularly when a member may be struggling. Members interviewed reported that because of some shared history, the staff is easier to trust. | |
| **Total Score:** | | 113 | | |

**ACT FIDELITY SCALE SCORE SHEET**

| Human Resources | Rating Range | Score (1-5) |
|---|---|---|
| 1. Small Caseload | 1-5 | 4 |
| 2. Team Approach | 1-5 | 4 |
| 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 | 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 | 4 |
| 3. Full Responsibility for Treatment Services | 1-5 | 4 |
| 4. Responsibility for Crisis Services | 1-5 | 5 |

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| 5. Responsibility for Hospital Admissions | 1-5 | 4 |
| 6. Responsibility for Hospital Discharge Planning | 1-5 | 5 |
| 7. Time-unlimited Services | 1-5 | 5 |
| Nature of Services | Rating Range | Score (1-5) |
| 1. Community-Based Services | 1-5 | 4 |
| 2. No Drop-out Policy | 1-5 | 5 |
| 3. Assertive Engagement Mechanisms | 1-5 | 4 |
| 4. Intensity of Service | 1-5 | 3 |
| 5. Frequency of Contact | 1-5 | 3 |
| 6. Work with Support System | 1-5 | 4 |
| 7. Individualized Substance Abuse Treatment | 1-5 | 4 |
| 8. Co-occurring Disorders Treatment Groups | 1-5 | 2 |
| 9. Co-occurring Disorders (Dual Disorders) Model | 1-5 | 5 |
| 10. Role of Consumers on Treatment Team | 1-5 | 5 |
| **Total Score** | 4.04 | |
| **Highest Possible Score** | **5** | |