ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 20, 2019

To: Angela Hill, ACT Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On January 28-29, 2019, T.J. Eggsware and Karen Voyer-Caravona 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 the Central Region of Arizona.

Terros offers services that include: wellness, primary medical, mental health, and substance use care. The agency operates multiple recovery centers in the Central Region of Arizona. The agency operates four ACT teams, two of which are located at the 23rd Avenue Recovery Center. This review focuses on the 23rd Avenue Recovery Center ACT Team One.

The individuals served through the agency are referred to as *clients* or *patients*, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

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

- Observation of a daily ACT team meeting;
- Individual interviews with the Clinical Coordinator (i.e., Team Leader); Employment Specialist (ES), Housing Specialist (HS) and a Substance Abuse Specialist (SAS);
- Group interview with four members receiving ACT services;
- Charts were reviewed for ten randomly selected members using the agency's electronic medical records system; and,
- Review of documents, including: outreach tracking, the Regional Behavioral Health Authority's (RBHA) *ACT Eligibility Screening Tool*, Clinical Coordinator (CC) face-to-face tracking log, group sign-in sheets, substance use treatment manual, resumes and training records for the SASs, ES and Rehabilitation Specialist (RS).

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 ACT team meets five times a week to discuss each member of the team.
- The team is of sufficient size to provide coverage to the 98 members. Some staff and a Nurse are scheduled to work weekend shifts.
- The team has two Nurses that provide services to members in the office and in the community. They coordinate with medical health care providers. During the team meeting observed, staff discussed member medical conditions and the Nurse provided guidance to staff.
- The team maintains low admission and closure rates. Fewer than six members joined the team monthly in the most recent six months. Staff reported that in the prior year, no members closed due to refusing services or moving from the geographic area without referral.

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

- Evaluate factors resulting in the team's limited involvement in member psychiatric hospital admissions. Discuss with members why they elect to self-admit without team involvement and inform them of team availability. Work with members and their support networks to discuss how the team can support them in the event of a psychiatric hospital admission.
- Increase the frequency of face-to-face contact and the amount of time spent with members. Based on records reviewed, members receive infrequent contact and a low intensity of service. Work with staff to resolve barriers. Review with staff to ensure they accurately document services rendered. Regular review of documented contacts may improve the team's application of this item.
- Engage ACT members who experience co-occurring challenges, as appropriate, to participate in individual and/or group substance use treatment through the team. Information provided revealed low participation in co-occurring group treatment. Consider increasing the number of substance use groups to allow at least one group to accommodate members in earlier stages of recovery and another to focus on those in later stages of recovery.
- Ensure all staff is knowledgeable of the stage-wise approach to substance use treatment including persuasion, engagement, active treatment, relapse prevention, associated treatment interventions and staff activities. The team could benefit from training on how stages of change align with stage-wise treatment interventions, developing treatment plans incorporating co-occurring treatment language, and strategies to engage members in individual and/or group treatment. Using a stage-wise model may enable staff to target specific interventions based on the member's stage of treatment.
- Engage informal/natural supports in member treatment. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports. Staff reported the team has four contacts a month with informal supports. However, based on observation of the team program meeting, staff referenced few recent contacts with natural supports. Contacts with informal supports were infrequently documented in member records.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of review there were 11 full-time staff working on the ACT team. Excluding the Psychiatrist, the member-to-staff ratio is under 10:1 for the 98 member program.	
H2	Team Approach	1 – 5 4	One staff estimated about 50% of members meet with more than one staff over a two-week period. Member records showed that 80% met with more than one staff over a two week period. A member reported meeting with zero staff in the week prior and one said they met with two staff. Another, who receives medication observation, reported seeing multiple staff. Staff stated they carry caseloads, but reported they serve the entire team. However, when responding to certain interview questions, some seemed uncertain about member statuses across the team. In a record it appeared a staff was unaware of a member's inpatient status.	• Ensure that ACT staff is familiar and work with all members; 90% or more of members should have face-to-face contact with more than one staff in any two week period. Contacts should be purposeful, directed at aiding and achieving recovery goals, and preferably occur in the community. • Evaluate team processes for sharing and disseminating information. Staggered schedules and weekend shifts allow the team flexibility, but there may be ways to enhance team coordination such as reading recent notes entered by other staff.
H3	Program Meeting	1 – 5 5	Staff reported the team meets Monday through Friday to discuss services to all members. Staff schedules include coverage for weekend hours, so not all staff works each weekday. Staff attends on weekdays they are scheduled to work.	
H4	Practicing ACT Leader	1 – 5 2	Due to the recent addition of the CC in January 2019, some of her time was spent transitioning into the role. This appeared to have an impact on the ability to provide direct services. Based on a productivity report, direct services accounted for less than 5% since joining the team. In records, there were few CC documented contacts.	• The CC should increase direct service provision with a goal of at least 50%. This should include meeting with members in the community, allowing for opportunities to train and mentor other staff in appropriate clinical interventions that follow the ACT model.
H5	Continuity of Staffing	1 – 5 2	Based on data obtained over the course of the review, 15 staff left the team in the most recent two-year period, a turnover rate of about 63%.	• Screen and orient prospective staff to assess their preparedness to deliver ACT services. Examine employees' motives for

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			Multiple staff filled the ES, RS, SAS and CC positions. Staff said that they were unaware of temporary coverage over the period.	resignation. Optimally, ACT teams experience no greater than 20% turnover during a two year period.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 86% of staff capacity over the past year, with 20 months of vacancies. Some positions, including RS, ES and ACT Specialist, were vacant for multiple months.	• Evaluate staff retention efforts. Fill vacant positions with qualified staff as soon as possible to ensure continuity of care.
H7	Psychiatrist on Team	1 – 5 5	Staff reported the Psychiatrist works four ten-hour days with the team, attends team meetings three to four days per week, and is accessible. The Psychiatrist wasn't present for the meeting observed. Staff said the Psychiatrist provides community-based services, scheduled for a half-day weekly. Staff stated he rarely meets with members from other teams. As the lead Psychiatrist for the center, he spends about an hour a week on associated tasks.	• Monitor time spent with lead tasks to assure the Psychiatrist's time is primarily allocated to the ACT team.
H8	Nurse on Team	1 – 5 5	The team is staffed with two Nurses. One is the lead Nurse for the center, and staff estimated she spends about an hour weekly in tasks associated with that role. Staff reported that the Nurses work almost exclusively with the members on the ACT team. The Nurses work four, ten-hour days and attend team meetings on the weekdays they are scheduled to work, unless emergencies arise. Staff reported one Nurse completes medication observation activities on their weekend shift. Both Nurses provide community-based services and an example was found in a record reviewed. Also, one Nurse documented contact with the legal system to determine if a member was incarcerated.	
H9	Substance Abuse Specialist on Team	1 – 5 4	The team is staffed with two SASs. One is a Licensed Associate Counselor (LAC) and has filled the role since April 2017. Prior experience includes nearly two years providing substance use	• Ensure staff receives training and supervision in substance use treatment by staff with the requisite experience. Evaluating and providing feedback to

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			treatment and two years employment at a detoxification facility. The second SAS joined the team in June 2018. She completed a master level program in Addiction Counseling in April 2017. The second SAS has less than one year experience providing co-occurring substance use treatment. Training records showed the SASs participated in little training pertinent to the position in the past year.	support specific skills (e.g., motivational interviewing) may aide the SASs as they deliver stage-wise interventions. With that support, they may be better equipped to cross-train other specialists. Optimally, both SASs have one year or more years' experience in co-occurring treatment.
H10	Vocational Specialist on Team	1 – 5 2	The team has two vocational staff, classified as ES and RS. The ES position was filled June 2018 and the RS position was filled December 2018. It does not appear either have one year or more experience assisting SMI diagnosed members to obtain competitive employment. Per resumes, both have experience in social service roles, not specific to vocational services. Records showed they participated in little pertinent training in the last year. Both completed a Disability Benefits 101 (DB101) session. The ES completed two trainings in Supported Employment.	• Ensure vocational staff receives regular training on resources, best practices and strategies to engage members to pursue and obtain competitive employment. Participating in meetings with other VS staff may aid them to share job leads or strategies based on their job development activities. • Review with staff on the team the benefits of competitive employment versus job-readiness or other adjusted work experiences.
H11	Program Size	1 – 5 5	The team is of sufficient size and diversity to provide coverage, with 11 staff, including: CC, ES, RS, Psychiatrist, two Nurses, two SASs, Independent Living Skills Specialist (ILS), Housing Specialist (HS), and Peer Support Specialist (PSS).	
O1	Explicit Admission Criteria	1 – 5 5	Staff said that the team controls admissions to the team, with no organizational pressure to admit. The team follows the RBHA's *ACT Eligibility Screening Tool*. Referrals originate from other teams at the center, other providers, or via the RBHA. The CC conducts most screenings. The CC and Psychiatrist review the screening information. The Psychiatrist reviews documentation in the health record if the member is an internal referral.	

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			The Psychiatrist makes the final determination whether members join the team. Due to the high census and regular rate of referrals, little active recruitment occurred.	
O2	Intake Rate	1 – 5 5	The ACT team admission rate was less than six members per month during the six months prior to review. The peak admission rate was two members per month during August, November and December 2018. No new members were added July 2018 and one member joined the team per month during September and October 2018.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The ACT team provides case management, psychiatry services and medication management, substance use treatment, the majority of housing support, and counseling is available. Staff reports differed on how many members reside in staffed residences. Nevertheless, less than 10% of ACT members appear to reside in staffed residences or receive in-home services from other providers. During the meeting observed, staff discussed members' housing statuses and the HS was identified to follow-up regarding housing issues. Staff said members are able to receive counseling inside the team. One SAS is a LAC and is available to provide counseling. Some staff were uncertain how many members receive counseling through the SAS. Staff said the team assists members with resumes and other job preparedness activities. During the team meeting, staff referenced members' status, for some, volunteering at the center or work adjustment training. There was limited evidence of engaging members for competitive employment.	• Provide on-going training and mentoring to the ES and RS on assisting members in finding and retaining employment in competitive/integrated settings. Ensure all staff on the team is trained on the benefits of competitive employment in comparison to sheltered work experiences. • Consider including member housing/treatment status on the team meeting log. Review with staff if this information and other pertinent data may help them to better track member statuses. Some data that may be useful include: stage of change/treatment for members with co-occurring diagnosis, employment status and informal supports.

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O4	Responsibility for Crisis Services	1 – 5 4	Staff reported the team assumes full responsibility for psychiatric crisis services. On-call and backup coverage is rotated weekly. Certain staff, including one of the Nurses, works weekend hours. Staff reported all ACT members are given a printed list of staff contact numbers when they join the team, and when staff join or leave the team. It was not clear if all members are informed to first contact ACT staff in the event of a crisis. One interviewee said the team on-call is available in a crisis situation, but others said they would contact the local crisis line. A staff documented in multiple records that members are aware of crisis services being available at the Urgent Psychiatric Care Center and Warm Line.	• Ensure members are aware that the team is available to respond to them after hours and in the community. Encourage members to first contact the ACT on-call. • Discuss as a team the role as a crisis responder, and strategies to improve members' understanding and use of the team as a crisis responder. Improved member understanding may positively impact members making contact with staff rather than self-admitting for psychiatric treatment without team involvement.
O5	Responsibility for Hospital Admissions	1 – 5 2	Staff reported that during business hours, members are transported to the center to meet with the Psychiatrist and/or Nurse if assessment for admission is needed. Staff said that after hours, most crises can be resolved over the phone using interventions such as contracts for safety. Staff assists if hospitalization is needed, transporting and staying with members until admitted. Based on review of recent admissions, the team was directly involved in the decision for three of the last ten; six members self-admitted without team involvement and one member was petitioned by an external support.	• Review with staff under what circumstances, if any, a contract for safety is an appropriate intervention over face-to-face support or other assessment and safety planning strategies to support members experiencing a crisis. • Increase member engagement. More frequent contact and a higher intensity of service may afford ACT staff more opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions when indicated, in addition to improving rapport with natural supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff said the team was involved in all of the ten most recent member discharges from a psychiatric inpatient setting. Staff stated they coordinate with inpatient staff and the Psychiatrist completes doctor-to-doctor coordination, an example of	• Track member hospitalization status, discharge planning and monitor follow-up services. Assign specific staff responsible for implementation and documentation. Review with staff barriers to adherence to

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			which was documented in one reviewed record. At discharge, staff said they transport members to their residence and ensure they have medications. Staff said they visit members within 24 hours of notification of admission and then meet them Monday, Wednesday and Friday. In a record reviewed there was a visit with a member who was inpatient. Staff called the hospital staff three days after the visit and learned the member discharged. A second visit was not documented and should have occurred per the visit schedule. A second member was not visited within 24 hours. Staff said they meet with members face-to-face daily the week after discharge and that members meet with the Psychiatrist within 72 hours of discharge. After a member discharged, daily attempts to contact the member were not documented in a record reviewed, nor was contact with the Psychiatrist within 72 hours.	the member hospital discharge process. Including, daily face-to-face contact the week after discharge and a visit with the Psychiatrist within 72 hours. It may be useful to document those plans and assigned staff in the member's record so all staff can access and be aware of the plan. • Coordinate with inpatient staff, members, and their supports (both informal/natural and formal) to reinforce the benefits of including the team in hospital discharges.
O7	Time-unlimited Services	1 – 5 5	Per staff report, four members graduated from ACT the prior year and about three to four are likely to graduate in the next year. Staff said they modify service plans if they intend to reduce contact per member request or in advance transitions to lower service levels. Staff stated two members elect to not have weekly contact with staff and their service plans reflect the reduced contact frequency. Staff said they received a list of potential graduates from the RBHA which included members who had not had a recent hospital admission. The team was asked to respond. Staff agreed to transition four of the ten members.	• Ensure ACT teams are empowered to decide, with members, when members are ready to transition off ACT.
S1	Community-based	1 – 5	Staff estimated the majority of their time (80-95%)	• Assist members to explore and access

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	Services	3	is spent in the community. Per records, a median of 52% of community-based contact occurred with members. Most members interviewed reported they often meet with staff at the clinic. During the meeting observed, staff reported encouraging members to participate in groups at the clinic. Staff documented in many records reviewed that they encouraged members to participate in clinic-based groups. There was a lack of evidence that staff prioritized assisting members to explore socialization options or other resources in members' communities.	activities in their communities. Work to shift the locus of service from the office to the community. ACT teams should perform 80% or more of contacts in the members' communities where staff can directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting. • Ensure all staff engages members in the community at a similar level as what was reported by staff interviewed. Documentation and tracking of staff community contacts may be useful.
S2	No Drop-out Policy	1 – 5 5	Based on staff report, it is uncommon for members to drop-out of ACT services. In the year prior to review, four members closed due to lack of contact, the team determined one could not be served and none moved.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff said they follow an eight week outreach checklist. There is no agency title head or revision date on the checklist so it is not clear it is a formal agency process or a team-specific checklist. Slightly varied outreach prompts are listed week-to-week with four columns to track attempts. In records, there were gaps in documented contact or outreach, including over two weeks for one member and over a week for two other members. For one of those members, over more than three weeks, one community-based and two office-based outreach efforts occurred. The next contact occurred at an inpatient facility.	• If members are not seen at the frequency indicative of ACT, consider starting outreach efforts immediately. • Evaluate how last contacts with members are tracked. Staff should coordinate contact and/or outreach plans; this collaboration usually occurs in the team meeting. Identify specific staff and activities they will complete. • Track outreach attempts to ensure they occur and are documented. Consider increasing community-based efforts. On the current checklist, not all weeks require at least two community-based outreach.
S4	Intensity of Services	1 – 5 2	The median intensity of face-to-face service time spent per member was under 28 minutes weekly, based on review of records. The member with the	• Intensity may vary based on where each member is in their recovery, but the goal of the team should be to provide members an

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			highest average amount of service time received just over 92 minutes a week.	average of two hours or more of face-to-face contact weekly.
S5	Frequency of Contact	1 – 5 3	The median weekly face-to-face contact was two per week based on records reviewed. The team averaged four or more contacts with two members. One received medication observation and the other regularly attended clinic-based groups. Members interviewed who attend clinic-based groups or receive medication observation reported they have frequent contact with staff.	• Increase the frequency of contact with members by ACT staff to average four or more face-to-face contacts a week. Ensure members who do not receive medication observation or do not attend clinic-based groups receive contact at a comparable frequency as those who elect to take part in those activities.
S6	Work with Support System	1 – 5 3	Staff estimates of members who have informal/natural supports ranged from a low of 50-70% to nearly all. Staff said the team maintains weekly contact with those supports. The frequency of contact reported by staff was not supported by other data sources. Documentation in records showed few staff contacts with informal supports, an average of 1.4 per member per month. During the meeting observed, staff cited recent or planned contact with natural supports for roughly 9% of members. It was not clear if staff regularly engage support systems in purposeful contact to aide members.	• Seek training and guidance, to enhance strategies for engaging informal supports. Optimally, ACT staff has contact with informal supports an average of four times or more monthly as partners in supporting members' recovery goals. • The team should encourage members to develop and identify their support systems. Discuss with members the benefits of involving those supports in their treatment. • Evaluate methods of tracking or monitoring staff documentation of contacts with informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported about 25 - 38 of the 50 members with a co-occurring diagnosis receive structured individualized treatment; other members are incarcerated or on outreach status. One SAS reported that she schedules about ten to fifteen individual sessions weekly and eight to eleven members participate; sessions range from 30-55 minutes. Staff was unsure about individual sessions scheduled or provided by the second SAS. Individual substance use treatment was reported by an SAS for ten members during the meeting	• Provide training and education to ensure the team is following an established co-occurring treatment model. • Engage members with a substance use diagnosis to participate in regularly occurring individual substance use treatment with ACT staff. Across all members with a co-occurring diagnosis, an average of 24 minutes or more of formal structured individual substance use treatment should be provided weekly. • Review documentation processes to ensure

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			observed. Records reviewed for three members with a substance use diagnosis showed two received zero individual sessions over a month timeframe. An SAS met with the third member for 14 minutes and discussed reducing use and frequency.	that all efforts are being recorded. The team reported more frequent services than were found in documentation. • Review activities assigned to the SASs that constricts their availability to provide individual substance use treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff reported each SAS facilitates a weekly substance use treatment group and that 15-20 members with a substance use diagnosis attended in a recent month. Staff reported the groups were open to other members at the clinic, not only this ACT team. As a result, SAS time spent providing services to members from other teams may inhibit their time dedicated to this team. Based on sign-in sheets, over a month, four of the 50 members with a co-occurring diagnosis attended group. Members with a substance use diagnosis attended groups facilitated by one SAS were verified by comparing participants with the co-occurring roster. Most of the members that attended groups facilitated by the second SAS, were not located on the team roster or co-occurring roster. Groups are not structured to serve members based on their stage of treatment. Staff reported members in any stage of change can attend any group. Additionally, it is unclear if the SASs draw from the same treatment materials. The topics of the groups facilitated by one SAS were general in nature and not located in the treatment manual utilized by the other SAS. During the team meeting observed, staff occasionally referenced member participation in	• Engage members with a co-occurring diagnosis to participate in treatment groups based on their stage of treatment. Optimally, 50% or more of dually-diagnosed members attend at least one substance use treatment group monthly. • Provide education and training to SASs and other specialist on a co-occurring treatment model including the stage-wise treatment approach (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). Standardizing treatment with purposeful stage-wise activities may help ensure consistent interventions are implemented by staff across the team. • Ensure co-occurring treatment groups reflect an evidence-based approach appropriately suited for the population served. • Consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach. • Review activities assigned to the SAS that takes time away from their availability to provide group substance use treatment to

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			groups. Based on records, no members sampled attended a substance use treatment group facilitated by ACT staff over a month timeframe. One attended a substance use treatment group that was not facilitated by staff from the team. The member was not identified as someone with a substance use diagnosis.	the members assigned to this ACT team. Consider assigning SASs to work primarily with members diagnosed with a substance use issue. • 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.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	It is not clear if staff have a shared co-occurring treatment approach. Staff reported the team follows Integrated Dual Disorder Treatment (IDDT). Training records did not indicate staff were trained in IDDT. Staff participated in Motivational Interviewing and substance use evidence-based practice training. Staff said they attain information from the SAMHSA website. Other than a manual, it was not clear what specific resources are used. The SAS utilizes the Counselor's Treatment Manual, Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders. This model does not appear to be the best fit for the population served. Not all members have a stimulant use issue. It is not a co-occurring model that aligns with the ACT emphasis on stage-wise interventions and staff activities. The model draws from the 12-step approach. In the manual, counselors are prompted to refer out for psychiatric care. Also, certain group topics in the treatment manual highlight abstinence. For members in earlier stages of treatment, those discussions do not align with stage-wise activities. Staff is not familiar with a stage-wise approach to	• Provide training and guidance to all staff on an integrated approach to substance use treatment, including a stage-wise approach (i.e., engagement, persuasion, active treatment, and relapse prevention). Having a common treatment approach should benefit the members served. Consider including member's stage of change/treatment on the team meeting log. • After the team shifts to a co-occurring treatment model, make available resources or materials utilized by the SASs to other staff to reference. • Provide feedback to staff on their interventions. For example, staff participated in Motivational Interviewing training. Consider using Motivational Interviewing feedback forms during supervision. • The team would benefit from review of how to incorporate interventions in treatment plans and notes. Align staff activities and interventions to each member's stage of treatment. • Review with staff the conditions when

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			treatment, but said they are familiar with the stages of change model. Members' stages of change were not discussed in the meeting observed and it was not clear how the team is made aware of that information in order to provide interventions accordingly. One staff said the team does not engage members to attend Alcoholics Anonymous (AA), but another was uncertain. It was not clear if staff have a shared understanding of specific circumstances when withdrawal management (i.e., detoxification) may be medically indicated. Service plans seemed to focus on symptoms of mental illness and a general list of services available to members. Most treatment plans for applicable members reviewed did not address substance use or, if present, did not identify team interventions that align with a stage-wise approach to treatment. Some plans contained elements indicating a template may be used. For example, a member's name and target symptoms listed in all capitals while other information did not follow that format. Plans also contained similar phrasing; for example, actively participate in his mental health treatment.	withdrawal management may be medically indicated versus circumstances when other interventions can be provided in lieu of detoxification. • As noted earlier in the report, regularly engage members to participate in individual substance use treatment and offer multiple co-occurring treatment groups to serve members in various stages of treatment.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has a Peer Support Specialist. Some staff interviewed were uncertain whether there are staff on the team with lived experience. Members interviewed were not aware if there was staff on the team with lived experience. One staff confirmed they were present when a staff shared information about their psychiatric recovery with a member.	• Confirm member perspective is represented on the team. Educate members and other specialists on the team of staff with lived psychiatric experience. Inform ACT staff how individuals with lived experience that work on the team can be a resource to staff and members.
Total Score:		**3.79**		

ACT FIDELITY SCALE SCORE SHEET

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

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	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.79**	
Highest Possible Score	**5**	