ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 7, 2022

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AHCCCS Fidelity Reviewers

Method

On November 30 – December 1, 2021, Annette Robertson and Nicole Eastin completed a review of the Valleywise Mesa Riverview 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 the Central Region of Arizona.

Valleywise, formerly known as Maricopa Integrated Health Systems, provides a wide range of inpatient and outpatient integrated health services in the Central region of Arizona. This review will focus on this stand-alone ACT team.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. Delivery of telehealth services, including phone only, were calculated for this review, however those totals are not included in calculating scores for those items that measure in-person contact between the ACT team and members. This review was conducted remotely, using video or telephone to interview staff and members.

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

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

- Remote observation of an ACT program meeting on November 30, 2021.
- Individual interview with the Clinical Coordinator (CC).
- Individual interviews with Substance Abuse, Housing, Rehabilitation, Team, and Peer Support Specialists.
- Individual phone interviews with four members participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic medical records system.

- Review of documents: Resumes and training records for the CC, Substance Abuse Specialist (SAS), and Vocational Specialist (VS); Client phone list; *Mercy Care ACT Admission Criteria*; *AHCCCS Medical Policy Manual, 1040*; sign in sheet from a recent substance use treatment group, tracking tool used by the SAS, and copies of cover pages of substance use treatment resources utilized by the team, among other documents.

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 review. 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 Psychiatrist provides a high rate of telehealth services. System stakeholders may want to evaluate the successful use of phone and videoconferencing services by the prescriber and how the team supported members in engagement, broadening access to services.
- The team values work with members' natural support systems. Natural supports are recognized for their stabilizing influence.
- Peer roles on the team are valued for their insight and ability to connect with members. Peers have equal responsibilities.

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

- Increase contact of diverse staff with members. Diversity of staff interaction with members allows the members access to unique perspectives and expertise of staff, as well as the potential to reduce burden of responsibility of member care on staff.
- ACT services should be delivered in the community, rather than in clinical office settings. ACT teams should deliver services where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural setting.
- ACT services should be responsive to member needs, adjusting in intensity and frequency as it relates to member's individual needs and preferences. Higher frequency of contact correlates to improved outcomes for ACT members.
- Lack of staff providing substance use treatment services impacts the team's ability to provide those services. Increase provision of those services. The team would also benefit from an improved understanding of co-occurring treatment services. Provide staff with annual training, minimally, and ongoing mentoring in a co-occurring disorders model, the principles of a stage-wise approach to interventions, and motivational interviewing.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, there were nine full-time equivalent (FTE) staff on the team, excluding the Psychiatrist. There were two open positions on the team. It was reported that 96 members are served resulting in an 11:1 member to staff ratio.	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff in order to maintain low member/staff ratio.
H2	Team Approach	1 – 5 3	Staff interviewed reported that 80% of members see more than one staff from the team a week. The team tracks contact with members during the program meeting, strategizing to ensure contact is made. Staff reported having an assigned caseload for administrative purposes. One staff said being understaffed impacts the ability to provide services to all members. Some members prefer contact by phone or videoconferencing due to the public health emergency. Members interviewed reported seeing ACT staff one to four times a week in-person. Of the ten randomly selected member records reviewed, nine received phone contact in a month period, one had videoconference contact, and 60% had contact by more than one staff in a two-week period. One record reviewed showed only two staff having phone contact with the member for a month period reviewed.	• Under ideal circumstances, 90% of ACT members have contact with more than one staff in a two-week period. Consider options to increase contact while following public health guidelines. • Increase contact of diverse staff with members. ACT team staff should be equally responsible for ensuring each client receives the services needed to support recovery. Diversity of staff interaction with members allows the members access to unique perspectives and expertise of staff, as well as the potential to reduce burden of responsibility of member care on staff.
H3	Program Meeting	1 – 5 5	Staff interviewed reported that the team meets four days a week for an hour to review all members on the roster. On a fifth day, the team meets for about two hours and has more in-depth discussions of member needs which may include updating treatment plans, reviewing court ordered	

			treatment paperwork, discharge planning for inpatient hospitalizations, and housing issues. The Psychiatrist attends the meetings four days in-person and was present at the meeting observed providing feedback and suggestions to the team.	
H4	Practicing ACT Leader	1 - 5 2	The CC estimates spending 10% of their time stepping in to assist the team in providing direct services to members. The CC reports assisting with medication observations, general check-ins, basic case management when there is a staff shortage, as well as providing in-home therapy to a couple clients. One member interviewed reported being provided therapy by the CC and was grateful for the service. Member records reviewed did not show any services delivered by the CC.	• 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. Shadowing and mentoring specialists delivering community-based services, such as outreach, and skill building activities designed to promote integration and recovery all qualify as direct in-person service. • The CC and agency might consider identifying administrative functions not essential to the CC's time that could be performed by the program assistant or other administrative staff.
H5	Continuity of Staffing	1 - 5 3	Based on information provided, the team experienced 54% turnover during the past two years. At least 13 staff left the team during this period which does include temporary coverage provided by an agency Psychiatrist. The SAS position had the highest turnover followed by the Housing Specialist.	• 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. • Ensure staff receive training and guidance applicable to their specialty position. Research shows staff remain in positions longer when supported in their roles • The agency may want to consider identifying contributing factors to high staff turnover and working to find solutions.

				Consider anonymous employee satisfaction 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 4	In the past 12 months, the ACT team operated at approximately 88% of full staffing capacity. Though sporadically filled, the Peer Support Specialist position on the team was vacant for six of the past 12 months.	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible with a goal of 95% full staffing annually. Timely filling of vacant positions helps to reduce potential burden on staff.
H7	Psychiatrist on Team	1 – 5 5	The Psychiatrist works four days a week, 7:30 - 4:30 and is available after hours and weekends to the ACT team by phone. Staff reported that the Psychiatrist is easily accessible and historically comes to the center on days off to attend to important correspondence relating to members' care. Assigned only the ACT team, the team has the psychiatrist mobile phone and will reach out for medication related issues after hours, not needing to be screened by the CC first. The Psychiatrist provides services beyond medication management. Records reviewed showed the Psychiatrist providing weekly psychotherapy to a member to treat Post Traumatic Stress Disorder. Additionally, records showed services being delivered telephonically to four unique members during the month period reviewed and one other member engaged via telehealth video.	
H8	Nurse on Team	1 – 5 5	The ACT team has two Nurses to support the care of the 96 members. Each work four 10-hour workdays providing coverage Monday – Friday to the members of the team. Aside from regularly attending program meetings, among their responsibilities the Nurses provide medical	

			support, coordinating with primary care physicians and specialty providers, administer medications and injections, and assist members in setting up medicine sets. Nurses do conduct visits in member homes to deliver and administer medication. Two days a week, Nursing staff participate in medication observation in the community and was noted in two member records reviewed. Staff interviewed stated that the Nursing staff are moving toward delivering even more services in the community. Nursing staff are not involved in delivering telehealth services at this time. Staff report the Nurses are readily accessible to staff.	
H9	Substance Abuse Specialist on Team	1 – 5 3	At the time of the review the team had one FTE SAS assigned to work with members of the team with a co-occurring diagnosis. The SAS has been serving members of the team for more than one year, has an undergraduate and graduate degree in Social Work, and experience providing services to transitional age youth and couples. Supervision is provided by the CC. Training records provided showed three trainings were completed in the two-years before the fidelity review relating to substance use; Motivational Interviewing, Co-occurring Disorders and Integrated Dual Disorder Treatment (IDDT) Basics, as well as trainings reported in personal medicine and a multi-day training relating to trauma and addiction.	• 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. • Provide annual training to SAS staff in co-occurring treatment best practices, including appropriate interventions, i.e., stage wise approach, based on members' stage of change. • Supervision should be provided by a qualified professional with substance use training and knowledge in treating members with a COD.
H10	Vocational Specialist on Team	1 – 5 2	At the time of the review the team had one new FTE Vocational Staff, a Rehabilitation Specialist (RS), assigned to work with members of the team. Training records provided showed the RS has attended one training related to assisting members in finding employment in an integrated	• Vocational Specialists obtain specific training and resources during the course of their work. These valuable skills and resources should be shared through cross training to other specialists on the ACT team.

			setting and Disability Benefits 101. The resume provided to reviewers shows the RS has less than one year of experience assisting persons with a serious mental illness (SMI) seeking and obtaining work in an integrated setting.	• Maintain two FTE Vocational Specialists on the team to ensure members' interests and needs for employment are met. When specialist positions are vacant, other staff should utilize skills and resources gathered through cross training provided by past staff providing employment services. • Ensure that vocational staff receive training in assisting people diagnosed with SMI/co-occurring diagnosis to find and retain competitive employment. Training should include techniques to engage members to consider employment; job development strategies; the importance of supporting in-person employer contact soon after members express an employment goal; and the provision of follow-along supports to employed members.
H11	Program Size	1 – 5 5	The ACT team has ten staff which is of adequate size to provide coverage. Two positions were vacant at the time of the review, the Employment Specialist and the second Substance Abuse Specialist.	
O1	Explicit Admission Criteria	1 – 5 5	Based on interviews with staff, the team follows the ACT admission criteria developed by the Regional Behavioral Health Authority. The CC completes most admission screenings. Another staff interviewed stated that when a potential member is ambivalent about the services, the team will follow up to provide additional information without questioning their final decision. The team Psychiatrist is involved in the admission process. The CC and Psychiatrist have the final determination after completing the screening, a review of the member's chart, and	

			coordination between the treating doctor and the ACT Psychiatrist.	
O2	Intake Rate	1 – 5 5	Per the data provided and an interview with ACT staff, ten members were admitted to the team in the six months prior to the review. This rate of admissions is appropriate, as there were never more than six new members admitted in a one-month period. The month with the highest admissions (4) was November when the team had two vacant positions on the team.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management, the ACT team provides psychiatric and medication management services, counseling and psychotherapy, and substance use treatment services. All members receive their psychiatric medications through the ACT team. One member interviewed reported appreciating the monthly therapy delivered by the CC, and a member record showed the Psychiatrist providing weekly therapy to another member. It was reported no members receive those services off the ACT team. Per data provided and staff interviews, more than 10% of members served by the team were reported to be living in residences with some level of staff support. Staff reported limited ability to meet with members in their supportive living environment at the request of the providers due to the public health emergency. It was reported, and observed in at least one member record, that the use of outside providers is utilized for employment services which includes work adjust training programs (WAT).	• Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff support. Monitor the number of members in staffed residences so that, optimally, no more than 10% reside in settings with other social service staff provide support. • Educate staff on the benefits of ACT staff engaging and directly supporting members with rehabilitation and competitive employment goals, rather than engaging them to participate in temporary WAT activities or employment services with brokered providers.

O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for its members. Staff considers themselves to be first responders in times of crisis. Occasionally members will contact the community crisis line, instead of the team, and the crisis staff will forward the call to the on-call ACT staff. Staff rotates coverage weekly with a primary and secondary on-call. The ACT CC is the third in line and is contacted when staff go out into the community to provide in-person support. The team provides a contact sheet with the ACT staff names and numbers and provides a laminated wallet sized card for members to carry on their person. One member interviewed stated a friend was provided a contact sheet. During the height of the public health emergency, the team continued to provide crisis services to members while taking appropriate precautions for members and staff.	
O5	Responsibility for Hospital Admissions	1 - 5 3	When members express a desire for inpatient psychiatric hospitalization, the team will meet with the member and assess. Sometimes members change their mind after talking with the team. When members are still requesting inpatient care, the team assists by transporting the member to the hospital of their choice. One staff denied the presence of a policy that members are screened by the Psychiatrist, yet another staff suggested members would benefit from screening prior to being transported to psychiatric hospitals. Staff will remain with the member until admitted however, some hospitals continue to limit staff ability to stay. For members showing an increase in symptoms, that may require psychiatric hospitalization but are not agreeable, specialists will assess in the community, encourage voluntary	• Frequent contact with members and their support networks may result in earlier identification of issues or concerns relating to member's symptoms. This would allow the team to offer additional supports, which may reduce the need for hospitalization. • Develop plans with members and their natural supports in advance for when considering the need for inpatient care, especially if they have a history of hospitalization without seeking team support. • Consider implementing a team protocol when assessing members for hospitalization that allows for interventions by more than one staff.

			hospitalization, and then consult with the Psychiatrist and CC for clinical direction. If needed, the team will complete necessary paperwork for involuntary hospitalization. Per the data provided and review with ACT leadership, the team was involved in 50% of the ten most recent psychiatric hospitalizations. Several members admitted on their own or it was unclear how they arrived at the unit, and at least one was assisted by a family member.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Based on data provided and reviewed with staff, the team was involved in 100% of the last ten psychiatric hospital discharges. Staff interviewed reported that when a member is admitted to a psychiatric hospital the team follows up with the social worker to coordinate and communicate the team's plan which may include housing or residential services. The team psychiatrist will coordinate with the inpatient prescriber. When members are ready for discharge, the team will arrange transportation to the clinic to review medication changes, providing five days of follow up, including four days of home visits. For members in behavioral health residential facilities, the team will contact by phone as some are limiting outsider contact to keep members safe during the public health emergency. The team will invite members to participate in the substance use group, when appropriate, and schedule with the Nurse as well. The team utilizes member calendars to track psychiatric hospitalization discharge planning as well as the supports and services the team provides after discharge. Calendars reviewed showed a team approach when providing follow	• Continue efforts to educate and inform inpatient psychiatric hospital staff of the availability of the ACT team to assist in the discharge process for members.

			up support for members after recently being discharged. Records reviewed showed one member had self-admitted to a local psychiatric unit. Coordination of care appeared to be hampered by the member being transferred between medical and psychiatric units. The team was not involved in the member discharge.	
O7	Time-unlimited Services	1 – 5 5	Upon review of records provided with staff, the team graduated two members from the team in the 12 months before the fidelity review. The team does not plan to graduate more than 1% of members in the next coming year. The team does offer a step-down system when members are opting to move to a lower level of care by reducing their contact with the member.	
S1	Community-based Services	1 - 5 2	Staff interviewed reported that approximately 70 – 80% of in-person contacts with members occur in the community. However, the results of the records reviewed show staff provided services 24% of the time in the community. Of the members interviewed two stated that in-person contact occurs most often at the clinic.	• ACT teams should deliver 80% or more of their contacts in the community where staff can directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting. Avoid reliance on clinic contacts with members as a replacement for community-based contacts. • For members coming into the clinic multiple times a week, the team should explore how to deliver those services in the natural settings where members live. • Ensure all staff engage members in the community at a similar level as what was reported by staff interviewed.
S2	No Drop-out Policy	1 – 5 5	Staff interviewed reported that two members left the area without a referral for ongoing services despite the team's efforts to coordinate. The team	

			was successful in supporting one other member in securing services when relocating to another state.	
S3	Assertive Engagement Mechanisms	1 - 5 4	During the program meeting observed, members were identified as requiring follow up due to lack of contact with the team. Staff were identified as having responsibilities to outreach the member in the community. Staff report use of member calendars to track the team's efforts to engage members in services and the team rallies when it comes to reaching out to disengaged members. Reviewers were provided the *AHCCCS Medical Policy Manual, 1040,* relating to re-engagement activities. Of records reviewed, one showed more than ten days of no contact or outreach to a member recently hospitalized. The team had not made any in-person contact with the member in the month period reviewed. Another record showed a member not having any outreach by ACT staff for two weeks.	• If members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Discuss and track these efforts during the program meeting. Consider peer review of documentation to ensure efforts are accurately included in member records. • Consider developing an ACT specific outreach protocol to guide staff on when to begin outreach efforts and the frequency of those attempts.
S4	Intensity of Services	1 - 5 2	Per a review of ten randomly selected member records for a month period before the fidelity review, the median amount of time the team spends in-person with members per week, is about 27 minutes. The highest rate of intensity was almost 89 minutes a week. Two records reviewed had no in-person contact by the team, however, one of those members did receive telehealth services (videoconference) from the Psychiatrist temporarily providing services to the team. Some staff interviewed expressed a lack of support of telehealth services.	• ACT teams should provide an average of two hours or more of in-person 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 by providing education on steps they can take to reduce the risk of infection, including vaccination, wearing of masks, and social distancing.

			The fidelity tool does not accommodate delivery of telehealth services.	
S5	Frequency of Contact	1 - 5 2	Of the ten records randomly sampled, ACT staff provided an average frequency of 1.5 contacts to members per week. The record with the highest averaged nearly eight, also logging the highest intensity of all records reviewed. One member appeared to be on outreach after a hospital discharge. Median phone contact by the team to members was three contacts in a month period reviewed. All but one member had contact by phone from the team documented in records. *The fidelity tool does not accommodate delivery of telehealth services.*	• While under the constraints of the public health emergency, leadership may want to work with staff to identify and resolve barriers to increasing the frequency of contact with members. This may include use of telehealth technologies widely utilized and supported through research for members fearful of meeting in-person with ACT staff, Telehealth for Persons with an SMI . Provide training and support to the team and members to improve ease of use and competency.
S6	Work with Support System	1 - 5 4	Staff interviewed reported that natural supports are integral to member care and often are contacted by family when members are having challenges. Natural supports offer structure in members' lives. One staff stated that family members are invited to attend some groups at the clinic. The team will engage with natural supports when members attend appointments at the clinic and provide the team number to reach out when needed. It was estimated 50 – 85% of the members on the team have a natural support. The CC tracks natural support contact during the program meetings by referencing member calendars that has the support listed and will prompt if no contact has been made. Specialists are responsible for reaching out to natural supports of the members administratively assigned. The team strives to have weekly contact and staff report some natural supports will call several times during the week to coordinate member care. Staff reported documentation of	• Continue exemplary efforts to engage members' natural supports in their recovery. Work to increase contacts with natural supports to an average of four per month for each member with a support system. As much as possible, contacts with informal supports should occur during the natural course of providing services to members.

			contact is easily recorded in the member electronic health record system. Although sound was very muffled and unclear at times during the meeting observed, the team referenced member calendars that identify natural support contacts. Natural supports were mentioned for at least 14 members. Most members interviewed reported staff having contact with their natural supports. The team reached out and involved natural supports for 80% of members' records reviewed.	
S7	Individualized Substance Abuse Treatment	1 - 5 3	There are 64 members on the team with a co-occurring disorder and of those, it was reported that 37 are receiving formal structured individual substance use treatment services by the one SAS on the team. Reviewers were told that the second SAS recently left the team and that normally the COD roster is split equally between SAS. Although there are other staff on the team with potential to provide substance use services, the SAS is the only staff providing the service to the 64 members with a COD. The SAS attempts to meet with each member assigned to offer services, however, some declined. The use of telehealth services has expanded member access to services however, staff find it difficult to assist with technology when members are under the influence. Telehealth services are offered as a last-ditch effort to engage with members. Member's substance use diagnosis, stage of change, stage of treatment, treatment modalities participating in, i.e., individual or group, and preferred contact day of the week is tracked by	• All ACT team staff should engage members with a substance use diagnosis to participate in regularly occurring individual substance use treatment with ACT staff. An average of 24 minutes or more of formal structured individual substance use treatment should be provided weekly across all members with a co-occurring disorder. • When the ACT team is not fully staffed with SAS, consider allowing the single SAS to focus on delivery of substance use treatment services to those members on the team with a COD. • Consider utilizing all staff qualified to provide substance use treatment services to members of the team. This would allow more members to receive the supportive services and could relieve potential burden on the SAS.

			the SAS. The SAS attempts to meet with members two times a week for approximately 15 minutes using *motivational interviewing* techniques, *harm reduction*, and the *stage wise approach* to substance use treatment. Resources provided to reviewers included *Motivational Interviewing, Miller and Rollnick*, and *Addiction Counseling Competencies, TIP 21*, *SAMHSA*, however, the latter is not identified as a best practice for persons with a COD.	
S8	Co-occurring Disorder Treatment Groups	1 - 5 2	The SAS leads one substance use treatment group to members of the ACT team weekly on Thursdays. A calendar provided to reviewers showed the group being offered on alternating Mondays and Thursdays. Resources cited as being utilized for group practice include *IDDT Recovery Life Skills Program, Hazelden* along with the stage wise approach to substance use treatment and *cognitive behavioral therapy* approaches. It was reported 3 – 4 members regularly attend the group offered by the SAS. Sign in sheets for the month before the review provided validated that estimate.	• The team should continue their efforts to engage members in group substance use treatment in the safest manner possible and as community health conditions allow. The SAS should continue to collaborate with other team specialists to engage members in co-occurring group participation with the goal of at least 50% of members with co-occurring diagnoses attending once monthly. • When fully staffed, considering 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. Group interventions should align with a stage-wise approach.
S9	Co-occurring Disorders (Dual Disorders) Model	1 - 5 3	The team provides a mixed approach to co-occurring disorder services. Treatment plans reviewed did not identify services the team would be providing members with substance use treatment disorders. Some staff interviewed expressed valuing an integrated approach of providing care for members with a co-occurring disorder, however others stated that services were	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Dual Disorders Treatment, in the principles of a stage-wise approach to interventions, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new or less experienced staff.

			separated, particularly when it comes to substance use treatment. Several staff interviewed reported most substance use services are provided by SAS. If members express an interest in self-help groups in the community, the team will assist them in finding those additional supports. One staff stated that supporting the member in goals identified is the focus of services provided and that abstinence is never the goal. Another stated that they advocate for harm reduction and the team supports the approach. Some members are offered rewards for small accomplishments such as attending an appointment. Staff expressed relying on the SAS to provide any substance use treatment services to members yet expressed valuing cross training when referencing other specialty positions on the team.	Identifying a co-occurring disorder model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in their recovery. • Encourage regular discussion at the program meeting regarding members' co-occurring disorder treatment needs, stages of change, and stage-wise interventions to be utilized to support members in moving toward recovery. • Ensure member treatment plans include goals related to recovery, steps they intend to take, and roles the ACT team will take to support the member. Include individual and group substance use treatment, as well as other supports members identify.
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff interviewed stated there is staff with lived psychiatric recovery on the team and at least two share their stories of recovery when appropriate with members. One staff reported that it depends on where the member is at in their recovery when deciding to share their story of personal recovery. Members have expressed feeling understood and less alone when staff have shared their stories. One staff uses their life experience to help the team bring focus to interventions.	
Total Score:		**104**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	3
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	3
10. Vocational Specialist on Team	1-5	2
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5

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