ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with the Western Interstate Commission for Higher Education Behavioral Health Program to conduct Fidelity Reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an Evidence-Based Practice (EBP).

Method

On July 22 – 24, 2024, Fidelity Reviewers completed a review of the Copa Health Metro Varsity 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.

Copa Health was founded in 1957 to provide advocacy for those with special needs. The organization has since expanded to provide services to several populations, including those with serious mental illness. Copa Health manages several outpatient behavioral health clinics and multiple ACT teams. The individuals served through the agency are referred to as *clients or members*, but for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to observe meetings, and to interview staff and members.

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

- Remote observation of an ACT team program meeting on July 23, 2024.
- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with Housing, ACT, Employment, and Peer Support Specialists for the team.
- Individual phone interviews with two members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, ACT Program Manager, and representatives from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; *Members of the Metro ACT Clinical Team* welcome handout; Co-Occurring Disorders Specialist's calendar; copies of cover pages of substance use disorder treatment materials utilized; co-occurring disorders treatment group sign-in sheets; Clinical Coordinator Productivity Report; resumes and training records for Vocational and Co-Occurring Disorders Specialist staff.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a 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 with little room for improvement*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Practicing ACT Leader: The team has a full-time dedicated ACT leader that engages in at least 50% of the expected direct service as other ACT staff. Service delivery includes the provision of support to members in their community.
- Psychiatrist on Team: The team has one full-time Psychiatric Nurse Practitioner assigned to the team. The Psychiatric Nurse Practitioner provides in-person services and meets members in their community.
- Explicit Admission Criteria: The team has clearly defined admission criteria and recruits members from within the defined target population. Staff denied external pressure to admit members that do not meet these criteria.
- Responsibility for Crisis Services: The team provides 24/7 coverage for members and reported providing members with information regarding the ACT team on-call number in the event of an emergency.
- Role of Consumers on Treatment Team: The team has at least one staff with lived or living psychiatric experience on the team that shares their story of recovery with members, advocates for members from the peer perspective, and shares the same responsibilities as other team staff.

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

- Team Approach: Increase the number of diverse staff seen by members and consider eliminating assigned caseloads to ensure 90% of ACT members have in-person contact with more than one staff in a two-week period.
- Continuity of Staffing: Reduce staff turnover to less than 20%. Sharing caseloads and cross-training staff can help reduce the potential of staff burnout.
- Community-Based Services: Increase the provision of direct services for members to be at least 80% within the community and document all services and the locations within member records.
- Intensity of Contact: Increase the average length of contact provided to members to two hours a week.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team serves 96 members with 8.05 full-time equivalent (FTE) staff, excluding the psychiatric prescriber and administrative staff. Positions on the team include two Nurses, one .90 and the other .15 FTE, one ACT Specialist, one Housing Specialist, one Peer Support Specialist, one Independent Living Specialist, one Co-Occurring Disorders Specialist, one Employment Specialist, and a Clinical Coordinator. The team has a member-to-staff ratio of approximately 12:1.	• Ensure necessary staffing for a member-to-staff ratio of no greater than 10:1, excluding the Psychiatrist. • ACT teams are designed with high-needs members in mind. The entire caseload should be shared across ACT team staff helping to prevent potential burden when supporting high-needs members, as well as ensuring members are provided adequate intensity and individualization of services.
H2	Team Approach	1 – 5 2	Of the ten randomly selected member records reviewed, for a 30-day period, a median of 30% received in-person contact from more than one staff from the team in a two-week period. Staff reported having assigned caseloads.	• Ensure 90% of ACT members have in-person contact with more than one staff in a two-week period. • Confirm attempts and successful contacts are documented in member records in a timely manner. • Eliminate “primary case manager” member assignments. The team approach of ACT ensures continuity of care for members and creates a supportive environment for staff, potentially reducing the burden of responsibility. ACT staff are cross trained to work as a transdisciplinary team rather than individual case managers. Further, ACT team staff collaborate on assessments, treatment planning, and day-to-day interventions.
H3	Program Meeting	1 – 5	The team meets in person four days a week to discuss the entire ACT Roster. The Psychiatric Nurse Practitioner joins in person for all weekly	

		5	meetings and was present during the meeting observed. During the meeting observed, all members were discussed. Staff reported on recent member contact or contact attempts, disposition, communication with natural supports or guardians, employment goals, job skills training for members seeking employment, and upcoming appointments. The current stage of change was reported for members with Co-Occurring Disorders. The Clinical Coordinator provided clinical direction to staff relating to the prioritization of service delivery to meet member needs.	
H4	Practicing ACT Leader	1 – 5 5	The Clinical Coordinator is assigned 1.0 FTE to the ACT team. Staff reported the Clinical Coordinator providing the following direct services to members: home visits, medication observations, meeting with members in the office, and attending staffing meetings with members. The productivity report provided for a 30-day period showed an average of 15 hours per week of direct services. The productivity expectation for the team is a minimum of 30 hours per week of direct services. In the program meeting observed, staff reported at least 20 recent direct services provided by the Clinical Coordinator both in the office and in the community.	

			Ten percent of records reviewed showed the Clinical Coordinator conducting home visits, working with members on independent living skills, and encouraging members to participate in groups. In member interviews, two members reported seeing the Clinical Coordinator regularly when attending groups at the office. *This item is dependent on the Provider productivity expectation.*	
H5	Continuity of Staffing	1 – 5 2	Based on information provided, and reviewed with staff, the team experienced a turnover of 75% over the past two years. In the past 24 months before the review, eighteen (18) staff left the team. The positions with the highest turnover were the Peer Support Specialist and Co-Occurring Disorders Specialist, with each having four staff vacating the role in the past 24 months. In members interviewed, a member reported frequent staff changes and expressed disappointment in losing staff they connected with.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff. Sharing the entire caseload across the team promotes collaboration and unity as the team works together to provide member services.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the team operated at approximately 86% of full staffing capacity. Positions with the highest vacancies include the Employment Specialist and the Peer Support Specialist, with each of these positions having seven (7) months of vacancies.	• Continue efforts to screen potential hires for the responsibilities of ACT services with the goal of operating at 95%, or more, of full staffing annually.
H7	Psychiatrist on Team	1 – 5	The Psychiatric Nurse Practitioner is assigned 1.0 FTE to the ACT team and serves as the psychiatric prescriber for all members. The	

		5	Psychiatric Nurse Practitioner delivers services four days a week, working ten-hour days. The Psychiatric Nurse Practitioner primarily meets with members in person at the office and will meet via telemedicine based on member preference or circumstances. Staff reported that the Psychiatric Nurse Practitioner delivers services to members in the community including home visits, visiting inpatient members when hospitalized, and visiting members when incarcerated in local jails. Staff reported that the Psychiatric Nurse Practitioner meets with members about once a month or more often as needed. The Psychiatric Nurse Practitioner is easily accessible to the team and can be reached in person, in the office or via chat applications. Outside of work hours, the Psychiatric Nurse Practitioner can be easily reached via phone and staff reported calling during emergencies. Both members interviewed reported seeing the Psychiatric Nurse Practitioner in person about once a month and one member reported meeting with the Psychiatric Nurse Practitioner in their residence every other month.	
H8	Nurse on Team	1 – 5 3	There are two Registered Nurses on the team. One Nurse is assigned .15 FTE to the team and recently transitioned to primarily serving other agency teams. The other Nurse is assigned .90 FTE and supports other agency teams as needed.	• Ensure appropriate ACT team coverage of two full-time 100% dedicated Registered Nurses per 100 members. • Monitor and minimize the amount of time the Nurses spend providing coverage to other ACT team members. Given the member census, the two Nurses should primarily serve Varsity members.

			Both Nurses support members by administering injections, preparing medications, checking medication logs, conducting health assessments, checking vitals, and coordinating member care with psychiatric inpatient teams, among other duties. Both Nurses provide services four days a week. One of the Nurses primarily serves members in the community and the other Nurse primarily sees members within the office but will see members within the community as needed. Staff reported both Nurses regularly attend program meetings and provide updates on members' disposition and recent or upcoming injections. One Nurse was in attendance during the program meeting observed. Staff reported that both Nurses are easily accessible, and the team communicates with them in person, in the office, or via chat applications. Of the members interviewed, one reported a Nurse transports the member to primary and specialty doctor's appointments.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	There is one Co-Occurring Disorders Specialist assigned 1.0 FTE to the team to serve the 54 members identified with co-occurring disorders. The Co-Occurring Disorders Specialist is provided clinical supervision by an agency supervisor that is a Licensed Professional Counselor. The Co-Occurring Disorders Specialist has been with the ACT team since April 2024 and the resume provided showed approximately one year of substance use treatment experience.	• ACT teams are staffed with two Co-Occurring Disorders Specialists for a roster of 100 members, each with one year or more of training/experience providing substance use treatment services. • Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the

			The Co-Occurring Disorders Specialist's training records had approximately three hours of training related to substance use training since starting with the program.	evidence-based practice of *harm reduction*; and *motivational interviewing*. On ACT teams, CODS have the ability to cross-train other staff, providing guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model utilized by the team.
H10	Vocational Specialist on Team	1 – 5 3	There is one Vocational Specialist assigned 1.0 FTE to the team. The Employment Specialist joined the team in late June 2024 and has one year of combined experience providing vocational support. The Employment Specialist has completed two hours of vocational training in the past year.	• Optimally, 100-member ACT teams are staffed with two Vocational Specialist staff. Ensure the staffing ratio aligns appropriately with the number of members on the census. • When the team is in a better staffing position, support Vocational Specialists to attend regional training and support meetings provided by the local mental health authority.
H11	Program Size	1 – 5 4	At the time of the review, the team was comprised of 9.05 FTE staff, including the Psychiatric Nurse Practitioner. The team had the following position vacancies: Co-Occurring Disorders Specialist and Rehabilitation Specialist. The team is not of sufficient size to adequately provide services to its 96 members. *This item does not adjust for the size of the member roster.*	• Ideally, ACT teams have at least ten (10) full-time staff providing direct clinical services to ensure diversity of coverage and individualization of care to members. Having ten staff also may help to prevent burnout considering the intensive nature of the work and the 24-hour crisis availability of the team to members.
O1	Explicit Admission Criteria	1 – 5 5	The team has a clearly defined target population and utilizes *Mercy Care ACT Admission Criteria* to screen potential admissions. Staff reported the team receives referrals internally, from other	

			ACT teams, and from the local contractor with a Regional Behavioral Health Agreement. The Clinical Coordinator and ACT Specialist are primarily responsible for conducting initial screenings. The screening process includes coordinating care with guardians or natural supports, having the potential member meet with the ACT team, and staffing with the referring provider. Staff reported that the Psychiatric Nurse Practitioner and member have the final say regarding admission to the team. Staff reported not experiencing external pressure to admit members that do not meet the criteria for ACT. There were three members with Intellectual and Developmental Disabilities identified on the roster.	
O2	Intake Rate	1 – 5 4	Based on the data provided, the highest admission rate for new members was in May 2024 (6). During the month of May 2024, the team had four vacancies and was understaffed.	• Ideally, new intakes do not exceed six each month for a fully staffed team. Consider staffing capacity when admitting new members to ensure the team's ability to provide them with intensive services to meet their needs and to alleviate the potential burden on staff.
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team provides psychiatric services and medication management, employment services, and substance use treatment. All 96 members receive case management on the team. Three members have Intellectual and Developmental Disability diagnoses and receive	• In the EBP of ACT, services are fully integrated into a single team with no, or very few, referrals to external providers. • Continue to monitor the number of members in staffed residences. As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to

			additional case management services off the ACT team. For psychiatric care and medication management, all members receive services from the Psychiatric Nurse Practitioner and Nurses assigned to the team. For employment services, approximately 20 members receive vocational or rehabilitative services, 17 members are currently working, and two members are interested in school. Of these members, two members receive supportive or sheltered employment services off the team. Individual and group substance use treatment services are available to all members. Staff reported that approximately seven percent of members with co-occurring disorders are receiving inpatient or outpatient substance use treatment services off the team. The ACT team does not get credit for providing psychotherapy or general counseling, or housing services. General counseling is provided by agency providers. Approximately five (5) members receive counseling services off the team. For housing services, 55 members are living independently and eight are living within ACT housing. Of the two members interviewed, one member reported that ACT staff were the ones that helped them get into their current ACT	move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all services and support from the team. • Counseling/psychotherapy is made available to members on ACT teams and is provided by ACT staff. This staff will also act as a generalist within the team. Consider exploring options to providing counseling services to members of the ACT team, either through new or currently existing ACT staff.

			housing. Approximately 19% of members reside in housing with support services provided by non-ACT staff. These services include three members that live within group homes, nine members in Behavioral Health Residential Facilities, four within short-term or transitional living, and two in recovery housing.	
O4	Responsibility for Crisis Services	1 – 5 5	Per staff interviews, the ACT team provides 24/7 crisis services to members. The Clinical Coordinator is also available by phone after hours to assist ACT staff when addressing crises. On-call coverage responsibilities rotate between staff weekly. Staff reported crisis services include providing support and coping skills to members by phone or visiting members in person when additional support or hospitalization is needed. Members are provided with a contact list that includes the after-hours on-call number. Members interviewed reported awareness of the on-call number and resources.	
O5	Responsibility for Hospital Admissions	1 – 5 2	Per review of data with staff regarding the ten most recent psychiatric hospital admissions over a two-month period, the team was directly involved in 33% of admissions. Staff reported the decision to admit members is initiated when staff notice concerning behaviors such as when a member stops taking medications or makes comments that suggest they may be a danger to themselves or others. The team will staff with the Psychiatric Nurse Practitioner and will assess the member in the office or in the community to determine if hospitalization is necessary.	• ACT teams performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. • Maintain regular contact with members and their support networks, both natural and formal. This may result in earlier identification of issues or concerns relating to members, allowing the team to offer additional support, which may reduce the need for hospitalization.

			When the decision is made for a member to be hospitalized, the member is transported by staff to the hospital. Staff reported staying with members through the intake process and involving natural supports when requested by members. When members decline hospitalization or when there are safety concerns in transporting the member, staff will file a petition, prompting an involuntary admission. Based on the hospital admissions data provided and reviewed with staff, 70% were self-admissions; the team initiated the hospitalization process for the remaining 30%.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per the review of data with staff relating to the last ten psychiatric hospital discharges over a two-month period, the team was directly involved in 100% of discharges. Staff reported that after members are admitted, staff have 72 hours to coordinate staffing with inpatient teams and conduct a visit with the member while inpatient. The staff are involved in discharge planning and when the member is discharge ready, staff coordinate transportation for the member from the hospital to the member's residence. After discharge, the team has 72 hours to have the member meet with the Psychiatric Nurse Practitioner. Per staff interviews and the provided outreach and engagement protocol, the team meets with the member in person for five consecutive days after discharge.	

O7	Time-unlimited Services	1 – 5 5	According to the data provided and reviewed with staff, four members graduated from the ACT team with significant improvement. Three members are expected to graduate in the next 12 months.	
S1	Community-based Services	1 – 5 1	Staff interviewed reported 35-80% of in-person contacts occur in the community depending on staffing capacity and member needs. Results of ten randomly selected member records reviewed showed staff provided services a median of zero percent of the time in the community. Per the records reviewed, the minimum average of community-based direct services was zero percent, observed in six records. The maximum average of community-based direct services was 93% for one record. Community-based services provided in the record review were staff conducting home visits, transporting members to and from the hospital, and visiting members while they were inpatient. Of the two members interviewed, one reported seeing staff most often at their residence and the other reported seeing staff most often at the clinic for group sessions.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. • Ensure all community-based contacts include the location of those contacts that occurred and are documented in member records.
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had five members that dropped out of the program in the past year. The team retained 95% of the total number of members served in the past 12 months.	

S3	Assertive Engagement Mechanisms	1 – 5 2	Per review of the provided outreach and engagement protocol, outreach begins when staff are unable to locate members. While on outreach, staff attempt to contact members four times a week for eight consecutive weeks; at the end of the eight weeks members are transitioned over to a lower (navigator) level of care. Staff reported outreach attempts are conducted by phone and in the community. Staff call hospitals, shelters, the morgue, and natural supports. Community-based attempts include going to the member's residence, visiting natural supports, and checking areas the member is known to frequent. Of the ten records reviewed, one record had documentation of a member missing an injection, and then no additional outreach attempts were documented; the member was amended 15 days later. Eight member records lacked evidence of assertive engagement by the team. Documentation ranged from 11 to 29 days without any contact from the team.	• Increase assertive engagement efforts with members. Ideally, outreach is carried out by multiple ACT staff, drawing from motivational interviewing skills, allowing members a diverse group with whom to connect and then documented in member records. • Ensure all outreach efforts, including letters, phone calls, and contact with formal and natural supports are documented in member records.
S4	Intensity of Services	1 – 5 2	Per a review of ten randomly selected member records, during a 30-day period before the fidelity review, the median amount of time the team spends in person with members per week is approximately 18 minutes. The highest weekly average for in-person services was approximately 162 minutes. Three records showed zero in-person contact occurred in the 30-day period reviewed.	• ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. Ensure services are accurately documented in member records.

			The median amount of time of contact with members via phone or videoconference was approximately one minute. *The fidelity tool does not accommodate delivery of telehealth services.*	
S5	Frequency of Contact	1 – 5 1	Of the ten records randomly sampled, staff provided a median frequency of less than one, .63, in-person contact with members per week. The highest weekly average of contacts was approximately eleven in-person contacts between the ACT team and the member. Three records had no in-person contacts documented in the 30-day period. The median number of alternative contacts with members via phone or videoconference was an average of less than one contact a week.	• Increase the frequency of contact with members, averaging four (4) or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. • Ensure staff are trained and supported in appropriate documentation standards to ensure that services delivered are appropriately reflected in medical records in a timely manner.
S6	Work with Support System	1 – 5 2	Staff reported that approximately 47% of members have identified natural supports. During the program meeting, staff reported communicating with approximately 38% of natural supports, excluding paid guardians. Staff reported speaking with all member's natural supports in the past 30 days and contacting these supports at least one to two times a week. Records reviewed did not indicate this level of contact. Staff interviewed reported documentation of natural support contact may not have been entered into member records due to being behind on tasks.	• Assist members in developing a natural, community-based support system. Active participation with peer-run programs is a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact. • Ensure all services are documented in member records including contact with natural supports. Records should also specify when a paid guardian is also the member's natural support.

			In the records reviewed, there was no documentation of communication with natural supports. One record showed communication with a guardian, but it was unclear if the guardian was also a natural support.	
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	Per the data provided and reviewed with staff, there are 54 members with co-occurring disorders. Staff reported all 54 members are offered individual counseling and approximately 49 engage in individualized substance use treatment. Staff reported that sessions are typically an hour, and the Co-Occurring Specialists see them individually about once a week. Per a review of the provided Co-Occurring Disorders Specialist calendar, an average of seven members were seen each week for individual substance use counseling sessions. In the records reviewed, there were three documented individualized substance use counseling sessions for two out of the seven members with co-occurring disorders. The sessions ranged from 16-37 minutes.	• Continue efforts to increase the time spent in individual treatment sessions and increase the number of members engaged so that the average time is 24 minutes, or more, per week across the group of members with co-occurring disorders. • See recommendations for *H9: Co-Occurring Disorders Specialist on Team*
S8	Co-Occurring Disorders Treatment Groups	1 – 5 2	Staff reported offering two weekly substance use treatment groups that are run by the Co-Occurring Disorders Specialist. Per a review of the group sign-in sheets provided, nine (9) unique members attended groups for an attendance rate of 17% among members with co-occurring disorders.	• Continue to engage members with co-occurring disorders to participate in group substance use treatment, as appropriate, based on their stage of change. Ideally, 50% or more of applicable members participate in co-occurring disorders group monthly.

			Of the ten records reviewed, two documented members attending substance use treatment groups in a 30-day period. The groups covered the following topics: coping with stress, sharing triggers and strategies to coping, how negative thinking impacts emotions, and causes of stress. Staff provided the following manuals utilized for substance use treatment: *Integrated Dual Disorders Treatment* and *Illness Management and Recovery* models.	
S9	Co-Occurring Disorders Model	1 – 5 3	Staff reported taking primarily a harm-reduction and non-judgmental approach for treating members with co-occurring disorders. Staff reported using motivational interviewing in the interactions with these members. In the program meeting observed, when discussing members with co-occurring disorders staff identified the member's current stage of change. Staff reported not referring members to traditional substance use model groups (e.g., *Alcoholics Anonymous*) but will not discourage members from attending off the ACT team. Staff reported referring members to detoxification programs. Staff reported some expectations of abstinence for members with co-occurring disorders. In the records reviewed, three of the six records of members identified with co-occurring disorders had substance use treatment goals in their treatment plan which included inpatient	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as *Integrated Co-Occurring Disorders Treatment*, in the principles of a *stage-wise approach* to interventions, the EBP of *harm reduction,* and *motivational interviewing.* • With staff turnover, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Identifying a co-occurring disorders treatment model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in recovery.

			substance use treatment as an intervention. One plan supported an abstinence-based goal.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff reported having at least one staff with lived or living psychiatric experience that shares their story of recovery with members, when appropriate, and advocates from the peer perspective. This staff shares the same level of responsibility as other staff on the team. Both members interviewed reported peers on the team sharing their lived experiences. One member interviewed reported that it is valuable knowing there is a peer on the team because it helps the member feel like one day they could also work as a peer support.	
Total Score:		**97**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	2
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	5
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	3
9. Co-Occurring Disorders 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
5. Responsibility for Hospital Admissions	1-5	2

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	1
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	2
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	1
6. Work with Support System	1-5	2
7. Individualized Co-Occurring Disorders Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.46**	
Highest Possible Score	**5**	