ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

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To: Dr. Karen Tepper, President & Chief Executive Officer

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Introduction

The 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 September 8 – 10, 2025, Fidelity Specialists completed a review of the **Terros Health - 23rd Avenue Health Center ACT 1** team. This review is intended to provide specific feedback on the development of your agency's ACT services in an effort to improve the overall quality of behavioral health services in Maricopa County.

Terros Health is a nonprofit health care organization serving communities across Arizona. The agency provides integrated care services, including primary medical care, mental health counseling, substance use treatment, housing support, and justice services. The agency operates multiple centers across the Central Region of Arizona, which includes five ACT teams. This review focuses specifically on the ACT 1 team based at the 23rd Avenue Health Center. The individuals served through the program are referred to as *members or clients*, 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 September 9, 2025.
- Individual videoconference interview with the Clinical Coordinator.

- Individual videoconference interviews with Co-Occurring Disorders, Vocational, ACT, and Peer Support Specialists.
- Individual phone interviews with five (5) members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, Program Analyst, Agency Compliance Supervisor, and representatives from the Arizona Health Care Cost Containment System (AHCCCS) and the contractor with a Regional Behavioral Health Agreement (RBHA).
- Charts were reviewed for 10 randomly selected members using the agency's electronic health records system. The sample included members from the following health plans: RBHA, Division of Developmental Disabilities, and Other (Medicare, private, or other source of coverage).
- Review of documents: *Mercy Care Admission Criteria*; ACT outreach and engagement guidelines; copies of cover pages of substance use disorder treatment materials utilized; co-occurring disorders treatment group sign-in sheets; and resumes and training records for the 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. The scale determines the degree of fidelity to the ACT model along three 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 and Key Recommendations

The agency demonstrated strengths in the following program areas:

- Program Size: The team is sufficiently staffed with 10 full-time equivalent positions, including the Psychiatric Prescriber, to provide consistent and diverse staff coverage to members.
- Responsibility for Crisis Services: The team provides 24/7 crisis support, and members interviewed confirmed awareness of this service and reported that they can easily reach a team member when needed.
- Hospital Discharges: The team was actively involved in 10 of the most recent psychiatric hospital discharges and remains engaged throughout members' hospital stays, coordinating follow-up between the ACT team, including the Psychiatric Prescriber and members' primary care providers.

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

- Continuity of Staffing: The team has had a turnover rate of 62.5% in the last two years, with 15 staff leaving the team. Attempt to identify factors that contributed to staff turnover or that support retention. Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their natural supports, as well as reducing the potential burden on staff. Additionally, members are burdened with being asked to reshare their histories which may include experiences of trauma.

- Co-Occurring Disorders Specialist: The team currently has one Co-Occurring Disorders Specialist for 98 members, below the ACT standard of two for a 100-member roster. Fill the vacant position and ensure Co-Occurring Disorders Specialists receive consistent training and regular supervision from a qualified professional to support delivery of individual and group substance use treatment within an integrated model.
- Co-Occurring Disorders Treatment Groups: The team provides two groups to support members at various stages of treatment; ensure one is structured for members in early recovery and one for later recovery, with interventions aligned to a stage-wise approach. Increase participation so that at least 50% of members with a substance use disorder attend monthly.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team currently serves 98 members and includes nine full-time equivalent (FTE) direct service staff. This excludes the Psychiatric Prescriber and administrative staff. The team has a member to staff ratio of 11:1. Staff on the team include the Clinical Coordinator (CC), Employment Specialist, Peer Support Specialist, ACT Specialist, Housing Specialist, Rehabilitation Specialist, Independent Living Specialist, Co-Occurring Disorders Specialist, and one Registered Nurse.	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 – 5 4	Staff reported that approximately 88% of members interact with more than one ACT staff over a two-week period. Caseload responsibilities are shared among specialists, with each staff overseeing approximately 10 members to manage administrative tasks such as updating service plans and assessments. Most staff reported not utilizing a particular system to ensure coverage of members. Staff will identify members during the program meeting that have not been recently contacted that need outreach that day and will sometimes rotate caseloads. Of 10 randomly selected member records reviewed for a month period, 80% of members received in-person contact from more than one staff during a two-week period. Members interviewed reported interacting with at least one to two staff weekly.	• In the EBP of ACT, 90% of members have in-person contact with more than one staff in a two-week period. • Consider employing a consistent contact strategy or protocol to ensure coverage of all members weekly (e.g., geographic or zoned approach, rotating member contact assignments).

H3	Program Meeting	1 – 5 5	Staff reported the team meets in person four days per week and reviews all members on the roster at each meeting. Attendance includes all staff on scheduled workdays. The Psychiatric Prescriber and Registered Nurse participate three times weekly and stay for the duration of the meeting. During the program meeting observed, staff discussed recent engagement efforts, planned outreach activities, and addressed member needs including medication management, substance use treatment and current stage of change, employment goals, housing support, and natural supports. The CC guided prioritization of service delivery. The Psychiatric Prescriber was not at the meeting observed due to scheduled time off at the time of the review.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated providing approximately 10 hours of in-person services weekly. Staff reported the CC providing a range of direct services including hospital coordination, completing group home intakes, covering for staff absences, and maintaining a small caseload. The productivity expectation for in-person service delivery is approximately 52 hours monthly for ACT staff. A productivity report for a recent 30-day period showed the CC delivered 5.4 hours of direct service, resulting in approximately 10% of the expected productivity for ACT staff.	• Optimally, the ACT CC delivers direct services to members which accounts for at least 50% of the expected productivity of other ACT staff. Increase the delivery of in-person member services. Practicing ACT leaders can engage in a range of member care needs including providing counseling/psychotherapy, facilitating or co-facilitating co-occurring disorders treatment groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffings, shadowing and mentoring specialists delivering community-based services, such as assertive outreach,

			There were three examples of the CC delivering direct services to members in the records reviewed. Examples of services documented in records reviewed included medication observation, updating service plans, and assisting with coordination of care with hospitalizations, and jail releases. *This item is dependent on the Provider productivity expectation.*	hospital visits, and skill building activities designed to promote integration and recovery. • Consider identifying administrative tasks currently performed by the CC that may be transitioned to other administrative or support staff if applicable.
H5	Continuity of Staffing	1 – 5 2	Based on information provided and reviewed with staff, the team has experienced a turnover rate of 62.5% during the past two years. Fifteen staff left the team in that period. The position with the highest turnover was the Registered Nurse with six staff that left the team.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports the therapeutic relationship between members and staff and promotes team cohesion. • If not done so already, consider examining employees' motives for resignation, and attempt to identify factors contributing to turnover.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the team has operated at approximately 92% of full staffing capacity. During this period, the Employment Specialist role was vacant for five months and the Housing Specialist position for four months.	• 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. • Support specialty staff to work in their area of interest and expertise with members. Research shows staff remain in positions longer when supported in their roles by being provided supervision and training in their specialty practice.
H7	Psychiatrist on Team	1 – 5 5	The team has one FTE dedicated Psychiatric Prescriber, a Doctor of Osteopathic Medicine (D.O.), that works four, ten-hour days. Staff reported that members have psychiatric	

			appointments approximately every 30 days, with flexibility for urgent follow-ups. The Psychiatric Prescriber primarily delivers services in person at the clinic, with home visits provided as needed for members with medical or transportation barriers. The Psychiatric Prescriber is accessible to the team in person, by phone, and email, including after hours and weekends. Per records reviewed, the Psychiatric Prescriber was documented in eight records providing direct support.	
H8	Nurse on Team	1 – 5 3	The team includes one FTE Registered Nurse (RN) that works four, ten-hour days. Staff reported that nursing responsibilities include coordination with the Psychiatric Prescriber, medication monitoring, administration of injections, medication education, triage of medical concerns, hospital liaison support, and home visits for members with significant health barriers. Records reviewed reflected nurse participation in home visits for medication management, vitals monitoring, and health education. Staff reported that the RN is readily available to the team, including after-hours and weekends in addition to regular business hours via text messaging, phone calls, and messaging applications.	• Ensure appropriate ACT team coverage of two full-time 100% dedicated Registered Nurses per 100 members. Having two full-time nurses is a critical ingredient of a successful ACT program.
H9	Co-Occurring Disorders Specialist on Team	1 – 5 2	The team currently has one FTE Co-Occurring Disorders Specialist (CODS) that has been on the team since April 2023. The resume and training records reviewed reflected limited recent training in evidence-based co-occurring disorders interventions. Staff reported receiving most formal training through agency-required	• Provide eight (8) hours of annual training to CODS in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach* and the evidence-based practice of *harm reduction*. The CODS support the team by cross-training staff and guiding interventions based on the members'

			Relias modules, with limited clinical supervision specific to substance use treatment.	stage of change and the co-occurring disorders model adopted by the team. • ACT teams have two CODS assigned to provide services to members. When screening potential candidates for the position, consider one year or more of experience working with members with co-occurring disorders and integrated care. • Ensure CODS staff are provided with regular supervision from a qualified professional to support delivery of individual and group substance use treatment services in an integrated treatment model approach.
H10	Vocational Specialist on Team	1 – 5 3	The team includes one Employment Specialist, on the team since March 2025, and one Rehabilitation Specialist on the team since April 2024. Reviewers received resumes for both specialists, which reflect relevant experience in supporting members with obtaining and maintaining employment in integrated work settings. Both specialists lacked recent vocational-related training.	• Provide ongoing training, guidance, and supervision to Vocational Specialist staff, including at least four (4) hours of annual training focused on employment and vocational support services. Training should emphasize best practices that help members obtain competitive jobs in integrated settings.
H11	Program Size	1 – 5 5	At the time of the review, the team was comprised of 10 FTE staff, including the Psychiatric Prescriber. The team is of sufficient size to adequately provide intensive and community-based services to members. The team identified one CODS position as the only current vacancy. It was indicated that ideally that candidate could also provide general counseling services to the ACT members. Per the model, the	

			team should also be staffed with an additional RN.	
O1	Explicit Admission Criteria	1 – 5 5	The team follows the *Mercy Care ACT Admission Criteria* to screen all referrals. Eligible individuals have a Serious Mental Illness (SMI) designation, demonstrate high service needs (e.g., recurrent crisis service utilization and/or recent hospitalizations), and have difficulty participating in traditional outpatient case management services. Willingness to participate in services is confirmed during screening. Referrals originate from internal programs, community hospitals, and the RBHA contractor. The CC conducts admission screenings and verifies eligibility. Final admission decisions are made with the ACT Psychiatric Prescriber after consultation with referring providers. Upon approval, staff contact the member to initiate services and schedule the first appointments.	
O2	Intake Rate	1 – 5 5	Based on data provided and interviews with staff, the team maintained an appropriate rate of admission. Over the past six months, the team has admitted a total of 11 new members, with no more than three admissions in any given month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services and medication management, substance use treatment, and employment/rehabilitation services. At the time of the review, no members were receiving psychotherapy or counseling from the ACT team and approximately two were referred off the team for such services.	*In the evidence-based practice of ACT, all member services are delivered by the ACT team. As a transdisciplinary service delivery model, area specialists are trained and cross trained to provide the core components of ACT: case management, psychiatric services, counseling/psychotherapy, employment and rehabilitation services, housing support, and substance use treatment.*

			Approximately 18 members reside in housing with support services provided by non-ACT staff.	• Make counseling/psychotherapy available to members on the team provided by ACT staff. This staff will also act as a generalist within the team. Explore options to provide counseling services to members of the ACT team, either through new or currently existing ACT staff. • More than 10% of members reside in settings where ACT services are duplicated. The ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team.
O4	Responsibility for Crisis Services	1 – 5 5	Staff and members reported that the team provides 24-hour crisis support through a rotating on-call schedule. Two staff are assigned on-call responsibilities each week, with one staff serving as the primary on-call staff and the other as back-up. When members cannot reach either on-call staff, the CC is available as backup to provide support or community response when needed. On-call responsibilities rotate weekly, excluding the Psychiatric Prescriber, RN, and CC. Staff indicated crisis response begins with phone triage and, when necessary, extends to an in-person response in the community. Members interviewed stated they have individual ACT staff phone numbers, the ACT team office number, and the on-call number, which are provided upon admission and	

			reinforced through contact lists and team brochures.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported that when member hospitalization is warranted, the team conducts phone triage, provides in-person response when safe, coordinates transport to the clinic for RN or Psychiatric Prescriber assessment, and facilitates hospital admission. Staff assist with court-ordered treatment petitions, provide medication logs and team contact information to hospitals, and designate the CC as the primary liaison. Team staff rotate visitation to hospitalized members every 72 hours, typically on Monday, Wednesday, and Friday. Based on data provided and reviewed with staff, the team was directly involved in approximately 40% of the 10 most recent psychiatric hospital admissions. These admissions occurred over a two-month period leading up to the review. Staff reported in six instances of hospitalization that the ACT team was not initially involved, as members either self-admitted, or were supported by residential staff or family members.	• ACT teams performing to high fidelity of the model are directly involved in 95% or more of psychiatric admissions. • Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can provide aid during admission, especially for members with a history of seeking hospitalization without team support. • For members in staffed settings, ensure regular coordination of care includes information related to how the ACT team prioritizes activities related to psychiatric hospital admission.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that discharge planning begins while the member is still hospitalized. The team participates in staffing, schedules follow-up appointments, and contacts informal support when appropriate. Upon discharge, ACT staff provide or arrange transportation home and deliver prescribed medications. Records and staff interviews confirmed that members are typically scheduled with the Psychiatric Prescriber, RN, and Primary Care Physician	

			within one week of discharge. Staff rotate home visits to maintain contact over five consecutive days to accommodate member transitions back into the community after discharge. Per review of data with staff relating to the last 10 psychiatric hospital discharges, the team was directly involved in 100%. These discharges occurred over a two-month period leading up to the review.	
O7	Time-unlimited Services	1 – 5 5	Data provided showed five members (4%) members graduated from the team with significant improvement in the past 12 months. Staff estimated four to five members are anticipated to graduate in the next 12 months.	
S1	Community-based Services	1 – 5 4	Staff interviewed reported that 80-90% of in-person contacts with members occur in the community. Results of 10 randomly selected member records reviewed show staff provided services a median of 78% of the time in the community. Most members reported that staff meet with them in their homes at least once weekly. One member reported meeting staff in their home at least once a month. Staff documentation reflected the delivery of home-based services such as medication observation, injection administration, and health education. Records also showed specialists conducting home visits to engage natural supports, providing life skills training, accompanying members to medical appointments, and delivering co-occurring disorder interventions in community settings.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities.

S2	No Drop-out Policy	1 – 5 4	According to data provided and reviewed with staff, the team had eight members that left the program in the past year. The team has retained 93% of the total number of members served in the past 12 months.	• ACT teams ideally retain 95% of the entire caseload yearly. Work to retain membership in ACT. Several factors can impact this number positively, including a clear admission policy, consistency in staffing, natural support involvement, assertive engagement practices, and taking a recovery perspective and client-centered approach with member care.
S3	Assertive Engagement Mechanisms	1 – 5 4	When members disengage in services, the team follows engagement protocol requiring four outreach attempts per week for at least eight weeks with at least two attempts in the community and two by phone or email per week. Outreach assignments are rotated among staff and responsibilities include home visits, checking frequented community locations and shelters, and contacting natural supports, hospitals, probation, and other systems. During the program meeting observed, staff discussed disengaged members, sharing updates on planned outreach attempts and specific community areas to be searched. Of the 10 member records reviewed, there were two records in which members had no documented outreach for 10 days or greater.	• Monitor documented outreach and contacts with members. It may be useful to assign one staff to verify documentation in member records (peer review) during the program meeting to confirm recent contacts or outreach efforts are entered. This may enable the team to proactively assign alternating staff to outreach in the event of lapses.
S4	Intensity of Services	1 – 5 3	Per a review of 10 randomly selected member records during a month period before the fidelity review, the median amount of time the team spent in-person with members per week was approximately 50 minutes. The highest weekly average for in-person services was 142 minutes while the lowest was 10 minutes.	• Evaluate how the team can engage with or enhance support for members that receive a lower intensity of service. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. • Ensure staff are trained in appropriate documentation standards so that services

				and service time are accurately reflected in member records.
S5	Frequency of Contact	1 – 5 3	Of the 10 randomly sampled records, ACT staff provided a median frequency of 2.13 in-person contacts with members per week. The data showed a range of weekly in-person contact frequency, with the highest at 11.75 contacts per week and the lowest at 0.5 contacts per week. Phone contact was documented in 60% of records, with a median frequency of .50. The median duration of all phone methods was 2.38 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the frequency of contact with members by ACT staff, optimally averaging four (4) or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have diverse needs/goals, and frequency of contact should be determined by those needs and immediacy. • The team may benefit from routinely reviewing contact data, assessing barriers to in-person service delivery, and integrating discussions of contact frequency into supervision and team meetings. These efforts can help ensure that service intensity remains aligned with member needs and the expectations of the ACT model.
S6	Work with Support System	1 – 5 3	Of 98 members served, 72 members (73%) were identified as having natural supports. Staff reported that contacts with supports happen at least once weekly, typically on Wednesdays, and should be documented in members' records. Interactions occur both in person and over the phone. Staff reported the discontinuation of monthly family support group a few months prior to the review. During the observed program meeting, staff discussed recent engagement with natural supports for 14 members.	• Increase contacts with natural supports to an average of four (4) per month for each member with a support system. As much as possible, contact natural supports during the natural course of delivery of services provided to members. • 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.

			Record review and program meeting notes showed an average of 0.6 contacts per month with these supports. Documentation of contact with natural supports was in 40% of member records, including one record that had three natural support contacts in a 30-day period.	
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	Per data reviewed and confirmed with staff, 60 members on the team have identified co-occurring disorders. Of these, approximately 10% (6 members) receive structured individual sessions, typically held once a week on Fridays by the CODS and lasting 60 minutes each. Interventions described included motivational interviewing, harm reduction strategies, and relapse prevention planning. Record review showed that 40% of sampled members were identified with co-occurring disorders. Among these, only one record documented two individual sessions specifically focused on substance use treatment, each lasting approximately 50 minutes. Documentation did not consistently reflect structured, stage-wise interventions.	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders. • Consider monitoring member engagement and participation in individual substance use treatment. • Explore training on strategies to engage members in substance use treatment. On ACT teams, all staff engage members with co-occurring disorders to participate in treatment based on their stage of change, with content reflecting stage-wise treatment approaches.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 2	The team offers two in-person substance use treatment groups weekly at the office, facilitated by the CODS. Staff reported that 7–10 ACT members with co-occurring disorders attend at least one group per month. Due to low attendance, group sessions incorporate mixed content to address members at different stages of change and recovery and include attendance by individuals off the ACT team. Reviewers were provided curriculum which does not align with the co-occurring disorders treatment model.	• Optimally, 50% or more of members with a substance use disorder attend at least one co-occurring disorders treatment group each month. On ACT teams, all staff engage members with co-occurring disorders to participate in treatment groups, based on their stage of change, with content reflecting stage-wise treatment approaches. • Co-occurring disorder treatment groups work best when based in an evidence-

			Group sign-in sheets indicated that eight unique ACT members (13%) attended at least one group in the past month. Record review did not show documentation of member engagement in groups.	based practice (EBP) treatment model. Consider structuring groups around proven curriculum for optimal impact. • Consider modifying one group to serve members in the earlier stages of change and one group to serve members in the later stages. This practice would allow members the opportunity to have more focused discussions relating to their stage of change.
S9	Co-Occurring Disorders Model	1 – 5 3	Staff reported using an integrated treatment model approach; and described familiarity with harm reduction and motivational interviewing. During the observed program meeting, staff identified stages of change for some members. Staff also used traditional language, which was observed in the program meeting and seen in documentation in member records, suggesting that COD principles are not applied consistently throughout the team. Reported interventions included harm reduction strategies such as supporting transitions to less harmful substances, education on naloxone use, promoting safe injection practices, and encouraging reduced use. Motivational interviewing was also applied, linking reduced use to employment goals and helping members set limits around substance use. The team does not routinely refer members to traditional substance use groups (e.g., Alcoholics Anonymous) unless specifically requested by the member. When clinically indicated, members are referred to detoxification programs for	• 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. • Provide training to staff on how interventions are more effective when they align with a member's stage of change, i.e., a *stage-wise approach*. Stage-wise treatment and interventions are an essential element of the Integrated Co-Occurring Disorders Treatment model.

			substances such as methamphetamine, fentanyl, or alcohol to support withdrawal management and facilitate entry into residential treatment programs. The CODS is not currently tasked with providing training on best practices in the co-occurring disorders model followed by the team. Staff reported that clinical oversight or group supervision was typically provided by agency leadership; however, it has been inconsistent in recent months and not specific to co-occurring disorders treatment. Of the four records reviewed for members with co-occurring disorders, three included treatment plans with substance use goals. Plans were written from the member voice.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has at least two staff with lived or living psychiatric experience, including one certified peer staff, that shares personal stories of recovery with members when appropriate. These staff share the same responsibilities as others on the team, and advocate from the peer perspective. One member interviewed was aware of peer staff on the team. Other members indicated that having a peer on staff would be beneficial to them.	
Total Score:		**106**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score
1. Small Caseload	1 - 5	4
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	3
9. Co-Occurring Disorders Specialist on Team	1 - 5	2
10. Vocational Specialist on Team	1 - 5	3
11. Program Size	1 - 5	5
Organizational Boundaries	Rating Range	Score
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	5
7. Time-unlimited Services	1 - 5	5
Nature of Services	Rating Range	Score
1. Community-Based Services	1 - 5	4
2. No Drop-out Policy	1 - 5	4
3. Assertive Engagement Mechanisms	1 - 5	4
4. Intensity of Service	1 - 5	3
5. Frequency of Contact	1 - 5	3
6. Work with Support System	1 - 5	3
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	**3.79**	
Highest Possible Score	**5**	