ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 29, 2016

To: Michele Swann, CBI FACT II Clinical Coordinator
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ADHS Fidelity Reviewers

Method

On January 5-6, 2016, T.J. Eggsware and Jeni Serrano completed a review of the Community Bridges, Inc. (CBI) Forensic Assertive Community Treatment (F-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 Maricopa County.

The CBI Forensic ACT (F-ACT) team is one of three ACT teams at CBI. The F-ACT team was located at the People of Color Network (PCN) Comunidad clinic, but the team was moved out of the Comunidad clinic as part of a larger transition when PCN services ceased September 30, 2015; management of the F-ACT team by CBI began October 1, 2015. Due to the transition, some information typically collected as part of a fidelity review was not available (e.g., staff records prior to October 1, 2015). This review focuses on current ACT services through CBI, but the timeframe of the review also includes when the team was managed through PCN, and as a result, some areas were impacted by missing or incomplete data. When applicable, the rating rationale will indicate how missing information impacted scoring.

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

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

- Observation of a daily F-ACT team morning meeting on January 5, 2015
- Individual interview with the Team Leader/Clinical Coordinator (CC)
- Individual interviews with Substance Abuse Specialist (SAS), Employment Specialist (ES), and Rehabilitation Specialist (RS)
- Group interview with five members, and a group interview with two members who receive F-ACT services
- Charts were reviewed for ten members using the agency's electronic health records system
- Review of the *F-ACT Admission Screening* and *ACT EXIT Criteria Screening Tool* developed by the Regional Behavioral Health Authority (RBHA)

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of

Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team currently has two full-time Nurses. The duties of the Nurses include conducting home visits, community medication observation, administering medications, attending daily morning meeting, and offering education to the members and the staff. The team Nursing services provided to members on the team includes a focus on those members with medical conditions, but they also conduct other activities such as helping members explore housing options, assisting members with benefit paperwork, helping members move residences, transporting members, etc.
- The team has small caseloads, with a member to staff ratio of four to one; this allows team staff to establish rapport and engagement with members. Based on staffing at time of transition from PCN, it appears CBI was prepared to serve more members than those who eventually transitioned.
- The team provides a high intensity, and frequency of services to members; services are delivered primarily in the community and not the office setting.
- Based on documentation, interviews with members, interviews with staff, and observation of the morning meeting, there is a team approach to treatment; members are familiar with staff specialty positions and duties, and staff share responsibility for member care.
- F-ACT staff attempt to build working relationships with legal system representatives.

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

- The agency needs to monitor duties and activities of the CC with a goal of at least 50% of the CC's time spent providing direct services to members; eliminate any responsibilities that are not essential, and determine what essential duties can be transitioned to other agency staff.
- The team needs to continue their efforts to involve members' identified support system; support and encourage members to identify their informal supports (i.e., people not paid to support members, such as family, landlord, neighbor, friend) and then assist them in acquiring the knowledge, resources and skills needed to support members. Consider developing a family psychoeducational group where families have the opportunity to expand their social networks, support each other, and learn techniques from each other on how to support members.
- The vacant SAS position should be filled by experienced staff so the team will be better positioned to provide individual integrated co-occurring treatment. Continue to engage members with substance use challenges to participate in individual and group treatment through the team. The team should implement a recognized integrated dual diagnosis treatment model to standardize the team approach when working with members with substance use challenges. Ensure ongoing supervision and training is provided to SAS staff, and empower SAS staff to cross train other staff.
- As the team census grows, it may be beneficial to review and plan with staff how they will manage a larger team caseload, while balancing a high intensity and frequency of service per member; there may be a period of adjustment for staff and members as the team

grows. Due to the low intensity of service for some members, the team should explore whether members who receive a lower intensity of service require additional engagement, or are being served fully through the team. For example, whether other providers are involved with services that overlap with the team and can be delivered through the F-ACT team. Some members may require an excess of two hours per week, while others less than two hours, but the program should consider monitoring the intensity of services across all members on the team.

- The RBHA, in collaboration with providers, should consider formalizing transition planning processes so that those steps are outlined if the need to transition a team occurs in the future. Engaging the members who transitioned from PCN to CBI or other providers to share their experiences, monitor their status, track outcomes, etc. may aid as transition planning processes are developed. Assessing the transition of the team from PCN to CBI may provide information to the RBHA on how to handle similar transitions in the future, if the need should arise.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	At time of review there were 42 members assigned to the program, which is a 4:1 member to staff ratio (excluding the administrative support staff and the Psychiatrist).	
H2	Team Approach	1 – 5 (5)	Members are assigned primary staff, but the team reported that the entire team shares responsibility for each member on the team. For example, the team approach was evident during the morning meeting when multiple staff provided planning input as members were discussed; sharing responsibility for treatment implementation across the team. Through review of ten member records, 90% of members had face-to-face contact with more than one team member in a two week period. Members interviewed stated they work with the whole team; members discussed the positions and duties of various specialty staff members on the team.	
H3	Program Meeting	1 – 5 (4)	The team meets four days a week Monday through Thursday for the daily morning meeting, and most staff members regularly attend, unless not scheduled to work, if in court, etc. At the time of review the Psychiatrist does not attend morning meetings, the Nurses or CC serves as liaisons between the staff and Psychiatrist. The CC reported that they are working on the technology needed to have the Psychiatrist attend meetings via video conferencing. All members on the team are discussed, even if only briefly, and the meeting observed lasted just over one hour. The culture of the team is such that the use of computers during the morning meeting does not appear to be a distraction, allowing staff to enter	• The F-ACT team Psychiatrist should attend morning meetings at a minimum one time a week. Some teams elect to have the Psychiatrist at all daily meetings; continue to evaluate program and member needs to determine if the Psychiatrist should attend daily meetings more than once a week. As the program builds and adds new members, staff may benefit from guidance and education through the Psychiatrist's direct input. • Optimally, all members are discussed at each team meeting. As the member census on the team increases, the structure and pace of discussion of members during the

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			updates to member status, schedule activities, and conduct other brief tasks as members are discussed. Along with maximizing staff efficiency during the morning meeting, there is evidence this team communicates effectively, using smartphones, texts, email communication, etc.	morning meeting should be closely monitored to ensure the meeting time is not excessive, while not sacrificing discussion of members served.
H4	Practicing ACT Leader	1 – 5 (3)	CC reports that 10-15% of her time is spent providing services directly to members currently assigned to the F-ACT team. Based on data provided over a month timeframe the CC provided direct services just under 20% of the time, but the information did not identify whether this included only current members of the F-ACT team. Based on documentation in ten member records reviewed, the CC provides services routinely including transporting members, conducting home visits, providing medication observations, participating in staffings, collaborating with informal and formal supports, etc.	• The CC should continue her efforts to provide direct services to members at least 50% of her time. While the team has a low member to staff ratio, the CC should seek opportunities to establish direct rapport with members so that those relationships can be maintained as the census increases. There may be opportunities for the CC to model interventions or provide guidance to staff in the field during member interactions.
H5	Continuity of Staffing	1 – 5 (1)	As noted above, management of the F-ACT team transitioned from the PCN Comunidad clinic to CBI when PCN operations ceased. Due to the transition, staff records were not available prior to October 1, 2015. However, none of the staff from PCN transitioned to CBI, which indicates the team experienced greater than 80% turnover in 2 years.	• Maintaining a consistent staff enhances team cohesion; additionally, consistent staffing enhances the therapeutic relationships between members and providers.
H6	Staff Capacity	1 – 5 (5)	As noted above, management of the F-ACT team transitioned from the PCN Comunidad clinic to CBI when PCN operations ceased. Due to the transition, staff records were not available prior to October 1, 2015. Based on available data, there were six vacancies for 12 positions since October 1, 2015, with the team operating at 95% capacity based on available data. Evidence supports CBI structured the team to be nearly fully staffed in	

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			preparation for the transition of the team from PCN to CBI.	
H7	Psychiatrist on Team	1 – 5 (4)	There is one Psychiatrist assigned 90% of the time directly to the 42-member program. The Psychiatrist has no other administrative duties outside of the team and does not regularly see members of other CBI programs during his time dedicated to the team. The Psychiatrist office is out of state and meets with F-ACT members via video telemedicine in the office setting. Communication with the Psychiatrist and some team members reportedly occurs with the Nurses or CC acting as liaison. Though some staff have not interacted directly with the Psychiatrist, staff do confirm the Psychiatrist is accessible; the Psychiatrist responds promptly to the team and service member issues (e.g., signing forms, scanning, and sending them back to the team). However, there are limits on the Psychiatrist's ability to function fully in the role, for example, conducting home or other community-based visits. Although some members report they prefer telemedicine contact with the Psychiatrist, others report they would prefer to meet with a Psychiatrist in person.	• The program should seek a permanent, full-time dedicated Psychiatrist to serve the members as the team census grows. Both members and staff can benefit from direct interactions with the Psychiatrist; some teams elect for the Psychiatrist and CC to share supervision of staff. In the meantime, the team should proceed with involving the Psychiatrist in the AM meeting via video conferencing as planned, and establish other parameters when staff can interact with the Psychiatrist directly.
H8	Nurse on Team	1 – 5 (5)	The team has two full-time Nurses for the 42-member program. Staff and members report the Nurses are accessible and available to members. Based on observation and documentation, the Nurses provide nursing services such as medication observation, medication education and monitoring, and serving as liaison with medical providers, and the team Psychiatrist. They also provide non-traditional nursing services such as helping people move into new residences, helping members search for new housing, and also carry a	• The RBHA should consider engaging the Nurses on the team to provide guidance to ACT Nurses on other teams if they are struggling with adjusting to the role of ACT Nurse. For example, a sample weekly schedule of F-ACT Nursing activities might be shared to show how the Nurses balance their responsibilities.

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			primary caseload. Based on observation, as well as staff and member report, the Nurses on the team provide services that are flexible and adapted to meet the needs of the members served; they are seen as vital members of the team. During the morning meeting the Nurses shared information related to medications, coordination with medical providers, and updated the team regarding member medical treatment.	
H9	Substance Abuse Specialist on Team	1 – 5 (3)	The team has one staff in the position of SAS. A Licensed Master of Social Work (LMSW), he has been with the team since October 1, 2015 in the role of SAS, and has seven months prior experience at CBI working with individuals with substance use challenges or co-occurring diagnosis.	• The team should have at least two staff members with at least one year of training or clinical experience in substance abuse treatment, per 100 members. Ensure SAS staff receives supervision and training related to appropriate assessment and intervention strategies to work with members to address co-occurring challenges.
H10	Vocational Specialist on Team	1 – 5 (2)	The team has two vocational service staff; the ES and RS started with the team when services transitioned to CBI on October 1, 2015. It appears the staff assists members in exploring employment options, but not with all phases of the employment search. Though staff appears to have a strong foundation in recovery, with the belief members can achieve goals, it does not appear both staff received training or has supervised experience in vocational services that enable members to find and keep jobs in integrated work settings. One staff reported some prior experience helping people find employment, but no formal training in the role. Due to the team composition of new staff following the transition from PCN, there is not enough data to support if vocational staff is offering vocational services that enable	• Ensure both vocational support staff receive supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings.

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			members to find and keep jobs in integrated work settings. The ES did report he is scheduled to meet with RBHA staff for training in January 2016.	
H11	Program Size	1 – 5 (5)	The team is of appropriate size with 11 staff (excluding administrative support staff); the team has one open SAS position.	
O1	Explicit Admission Criteria	1 – 5 (5)	Though the F-ACT team does not actively recruit, the CC reports the team receives an adequate number of referrals and the census is increasing. The team does serve a defined population, with referrals via jail release planners, the Arizona Department of Corrections, other clinics, etc. Members are screened for F-ACT using the *F-ACT Admission Screening* criteria developed by the RBHA; the team makes the final determination regarding admissions to the team, with no administrative pressures to accept referrals the team does not feel are appropriate.	
O2	Intake Rate	1 – 5 (4)	On October 1, 2015, the team transitioned 20 members out of 100 from PCN to CBI services. Since these members remained with the team during the transition from PCN to CBI, they are not factored into the count of intakes; these members did not change teams, but experienced a change in provider. The CC reports that following the initial team ramp up following the transition from PCN, through coordination with the RBHA, the team is now on track to accept six to seven intakes a month. The peak intake rate in the six months prior to review was nine members in November 2015, with seven member intakes for December 2015, and six new intakes for October 2015. Data for June through September 2015 was not available.	• Admit members at a low rate to maintain a stable service environment; admissions should be no greater than six per month. Once the team has operated for an extended period of time under CBI, and F-ACT team meets full capacity, the monthly intake rate will most likely stabilize.
O3	Full Responsibility	1 – 5	Although staff is assigned primary caseloads,	• The agency, in collaboration with the RBHA,

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	for Treatment Services	(4)	members are aware of a spectrum of services available through the team; members are familiar with staff specialty positions and duties. In addition to case management, the team provides medication prescription, administration, monitoring, and documentation, individual supportive therapy, and substance abuse treatment. Counseling is provided through the team to most members who receive that type of support, unless they receive specialized treatment (e.g., Dialectical Behavior Therapy). The F-ACT team offers individual and group substance abuse treatment, and most members who receive support in the area receive the service through the team. The team refers members to Consumer Operated Service providers for socialization and activities. This is not a service the team would be able to replicate under the F-ACT model, and the primary program where members are referred is also known to serve individuals with legal issues. It does not appear the F-ACT team provides 90% or more of housing and employment/rehabilitative services directly. The F-ACT team explores multiple options for housing and offers support to members in the community. However, some members are in staffed residences with support that appears to overlap with F-ACT housing support services. Additionally, the team utilizes other CBI programs for housing support; some member records reviewed reflected a high level of service from CBI Access or Transition Point facility staff. These supports seem to overlap with F-ACT team in home support services; some F-ACT members may have extended lengths of stay (i.e., more than three to five days). The F-ACT team refers	should continue to review training and supervision options to ensure staff designated with a specialty area receives monitoring, support, and supervision specific to their role. See also recommendation for H10 regarding training of vocational staff. • The agency should consider tracking referrals from the F-ACT team to external providers. Optimally the team should directly provide a spectrum of services, including vocational and housing supports, 90% or more of the time to members who receive support in those service areas. Due to the low member to staff ratio, it may be beneficial to empower staff in the specialty positions so they can establish those roles now and carry on with those duties as the team grows. • The agency and RBHA should discuss the pros and cons of developing alternative short-term housing for F-ACT members where the F-ACT team is the primary service provider.

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			members to external employment support agencies, though as ES and RS staff members familiarize themselves to their roles, they appear to become more aware that some of these services overlap with ACT services. While accompanying a member for intake through an external employment service provider, one F-ACT staff member realized, after learning more about their services, that those services overlap with ACT responsibilities. Staff members report they are scheduled to meet with RBHA staff in January 2016 to learn more about vocational supports.	
O4	Responsibility for Crisis Services	1 – 5 (5)	The team is responsible for crisis support. A form is provided to members with staff contact names, positions, hours of availability, and the on- call number for crisis services. Members are aware of staff contact information.	
O5	Responsibility for Hospital Admissions	1 – 5 (4)	Some clients choose to self-admit without informing the team. Of the four members admitted after October 1, 2015, the team was involved in admissions for three individuals (75%), with one person experiencing recurring hospitalizations. The team attempts to divert hospital admissions when possible, utilizing CBI Access and Transition Point to assist with monitoring medications, and to help members get through a crisis. Staff estimates they are involved in the majority of hospital admissions due to frequent contact with members.	• Continue to work with each member and their support network to review how the team can support them to potentially divert, or to assist in a hospital admission, if the need should arise. Continue to educate inpatient staff and administrators about the F-ACT team, including contact information and team structure.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	Staff reports they are involved in all hospital discharges. Members who recently discharged were discussed in the morning meeting, and the CC reports staff attempt to see inpatient members every 72 hours, coordinate with inpatient Social Workers, facilitate doctor-to-doctor consultations	

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			for new admissions and recurring doctor-to-doctor consultations if members remain inpatient. After discharge, F-ACT supports include increased staff contact with members for daily visits for five days or more, and assisting with re-integrating members in the community.	
O7	Time-unlimited Services	1 – 5 (5)	Per data provided, when the team was managed by PCN there were 100 members. Of those members, prior to transition to CBI, five members closed, 47 members transferred to other ACT teams (i.e., not other CBI ACT teams), 27 members stepped down to Supportive treatment, one member's status is not clear (i.e., marked NA on transition documents but reason is not identified), and 20 members transitioned to this CBI F-ACT team. Although many members did not transition from PCN to CBI, this appears to be a one-time event, and there are no projected graduations or step-downs in the next 12 months identified by the CC. As a result, it appears all members are served through CBI on a time-unlimited basis, with fewer than 5% expected to graduate annually.	• ACT services are designed to be available for as long as the member wants them; transitioning members prematurely can contribute to regression. The RBHA, in collaboration with providers, should consider formalizing transition planning processes so that those steps are outlined if the need to transition a team occurs in the future. Engaging the members who experienced the transition from PCN to CBI or other providers, monitoring of their status, outcome tracking, etc., may aid as transition planning processes are developed.
S1	Community-based Services	1 – 5 (5)	The F-ACT team staff is mobile and has access to technology and resources to support their provision of community-based services to members. For example, staff is provided laptops with Wi-Fi connectivity, smart phones, and access to company vehicles. Although the team maintains some office space for meetings, groups, etc., staff members reportedly spend most of their time in the field with a focus on supporting members in the community. Some F-ACT staff activities occur at other CBI facilities; those other CBI facilities were considered office-based for the purposes of this review. Staff	

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			estimates ranged from 85-95% of time spent in the field, consistent with data in ten member records randomly selected for review. The median ratio of services delivered in the community verses those delivered in the office was 85% community-based contacts, with six of ten members receiving 80% or more of contacts in the community.	
S2	No Drop-out Policy	1 – 5 (4)	As noted above, per data provided, the original census was 100 members when the team was managed through PCN. In the process of transition to CBI, five members closed and one member's status was not clear, which is a 6% drop-out rate. Although 47 members transitioned to other ACT teams, and 27 members transitioned to Supportive teams, those members were not factored in calculating this area.	• See recommendation for item O7.
S3	Assertive Engagement Mechanisms	1 – 5 (4)	Based on observation of the morning meeting and interviews with staff, it appears the F-ACT team uses outreach and engagement mechanisms, including coordination with Probation or Parole Officers (PO) or other legal system representatives, attending court with members, and coordination with payee services. Though, if these more formal supports are not involved it is not clear if the outreach is structured and individualized, but staff report they do try to obtain information from members regarding what areas of town they frequent, or whom the team can contact if members are not in contact with the team; staff is not aware if there is a formal policy or procedure for outreach.	• The agency should consider developing and documenting a formal outreach policy, process, or procedure for ACT members who are not in contact with the team, outlining minimum expectations for outreach efforts, etc. If a formal policy, process, or procedure exists, ensure staff is trained and familiar with that information.
S4	Intensity of Services	1 – 5 (5)	The median intensity of service per member was 225 minutes a week based on review of ten member records, nearly doubling the two hour per week of face-to-face contact per member	• As the team census grows, it may be beneficial to review and plan with staff how they will manage a larger team caseload, while balancing a high intensity of service

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			expected. It appears this high intensity of service may be associated with the low member to staff ratio. Though eight members received an average of more than 200 minutes of face-to-face service per week, three members received less than 50 minutes of face-to-face service.	per member; there may be a period of adjustment for staff and members.
S5	Frequency of Contact	1 – 5 (5)	The median weekly face-to-face contact for ten members was 6.88 based on record review. Staff estimates a high frequency of contact with members. Members interviewed stated they do see F-ACT staff regularly, mostly in the community, with more frequent contact if they attend groups or receive medication observation support through the team. Staff report they are working with members to create calendars so things such as appointments, activities, or tasks can be tracked by staff and members as they work toward goals.	• See recommendation for item S4.
S6	Work with Support System	1 – 5 (2)	The data provided implies the F-ACT team provides occasional interaction with members' support systems. The ten member records reviewed indicated that the team averaged .90 contacts per month with members' support systems. The CC reports approximately 20% of members on the team have supports, with the team having daily contact for some, but contact at least twice a month on average. Some members interviewed reported that the team is in contact with their supports. The team discussed informal supports for about 23% of the members during the morning meeting observed, though it was not clear if the team was in contact with all informal supports; communication with formal supports (e.g., probation, parole) was reported more frequently. During interviews, staff had some difficulty estimating the average monthly contact with informal supports for the entire team, noting that	• Continue to ensure F-ACT staff reviews with members the potential benefits of engagement with informal supports, and attempt to secure a Release of Information (ROI) allowing staff to contact identified supports. • If a member declines to allow staff to make contact with informal supports this should be documented in the record. However, staff can generally receive information from informal supports and may be able to share limited data with known supports in some situations. If necessary, review confidentiality guidelines when developing an agency plan to engage informal supports. • Focus on documenting team contacts with member support systems in a consistent

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			informal support involvement varied from member to member, and that information regarding informal supports for incarcerated members may not be known.	fashion, to ensure this measure is being accurately captured. • Consider developing a family psychoeducational group where families have the opportunity to expand their social networks, support each other, and learn techniques from each other on how to support members. • Consider tracking staff contact with informal supports, engagement efforts, etc. in the morning meeting.
S7	Individualized Substance Abuse Treatment	1 – 5 (4)	The team reports 30 of the 42 members served by the team face co-occurring challenges. The team SASs offer formal individualized substance abuse treatment; approximately 23% of members with co-occurring challenges receive weekly individual treatment for 45 minutes to an hour. This frequency and duration is consistent with information in some member records reviewed. It is estimated, on average, that all members with co-occurring challenges spend less than 14 minutes a week in individual treatment.	• The agency should fill the vacant SAS position so that the team has at least two full time staff with one year of training or clinical experience in substance abuse treatment; continue efforts to provide supervision and training to SAS staff. • Continue efforts to engage members in treatment through the team, and to build working relationships with correctional system representatives in order to demonstrate that the F-ACT team is capable of providing substance abuse treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	Based on staff report, approximately 17% of members with substance abuse challenges attend group treatment through the F-ACT team at least once monthly. The SAS utilizes a curriculum developed by the RBHA, as a base, allowing members to check-in and then processing topics as they arise. The SAS also relies on supervisors at CBI and his prior experience to guide his group facilitation approach.	• See recommendations for item S7. • Continue to explore engagement strategies that will increase member attendance. (i.e.; open house, motivational interviewing, etc.).
S9	Co-occurring Disorders (Dual	1 – 5 (4)	The team is aware of a stage-wise approach to treatment, though the language may not be	• Continue efforts to implement a consistent, harm-reduction based treatment model

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	Disorders) Model		incorporated into morning meeting discussions or day-to-day documentation. For example, in documentation it was noted one member was in the denial stage. Most staff appear to support a harm-reduction approach, assist members accessing self-help groups, occasionally refer to detoxification services if deemed medically necessary, but staff did not identify a specific treatment model that unified the team approach. Based on documentation and observation of the morning meeting, there is evidence the team generally attempts to build rapport with members, and supports a culture of honest communication about substance use through a non-judgmental approach. When substance use is suspected or reported, the team seeks to educate members about substance use and its impact on mental health conditions, to set goals, and to work with members to build awareness of problems.	that can unify the team approach; empower SAS staff to cross train other staff. • Establish methods for tracking member progress through the stages associated with a dual diagnosis treatment model. As members improve (or decline), SAS staff can communicate the effective interventions associated with that particular "stage of change" to other team staff with the intention of improving treatment planning outcomes and increasing member participation in substance abuse treatment. Standardize the team Integrated dual diagnosis treatment approach. Ensure the team language aligns with a recovery approach.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	Persons with lived experience of recovery are employed on the team full-time, with full professional status, and the F-ACT team has an identified Peer Support Specialist (PSS). F-ACT staff includes those with a history of substance use, and with lived experience of mental illness. Members and staff confirm that staff shares their personal stories with members; members report during interview they relate more closely with staff who have shared experiences.	
Total Score:		**4.07**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
3. Program Meeting	1-5	4
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	1
6. Staff Capacity	1-5	5
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	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	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	4
6. Responsibility for Hospital Discharge Planning	1-5	5

7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	5
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	5
5. Frequency of Contact	1-5	5
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.07**	
Highest Possible Score	**5**	