ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with 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, an evidence-based practice (EBP).

Method

On September 13 – 14, 2022, Fidelity Reviewers completed a review of the Terros 23rd Ave Assertive Community Treatment (ACT) 1 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.

Terros offers services that include primary medical care, behavioral health, and substance use treatment care. The agency operates multiple recovery centers in the Central Region of Arizona. The agency operates four ACT teams, two of which are located at the 23rd Avenue Health Center. This review focuses on the 23rd Avenue Health Center ACT Team 1.

The individuals served through the agency are referred to as *clients* and *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 psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing or telephone to interview staff and members.

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

- Remote observation of an ACT team program meeting September 13, 2022.
- Individual interview with the Clinical Coordinator.
- Individual interviews with Co-Occurring, Housing, Employment, and ACT Specialists.
- Individual phone interviews with five members participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; *ACT 1 Meet your Team*; *ACT Outreach and Engagement Policy;* resumes and training records for Vocational Specialists and Co-Occurring Specialists; tracking tool used by the Co-Occurring Specialist for individual co-occurring disorder treatment; Natural Support tracking tool; sign in sheets for co-occurring disorder treatment groups for the month prior to the review; Clinical Coordinator productivity report for a month period prior to the review; and copies of cover pages of materials utilized for co-occurring disorder treatment, among other documents.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries, and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team is of sufficient size to provide coverage to the 100 members, with only one vacant position, the Peer Support Specialist. The team has an appropriate member to staff ratio of 10:1
- The ACT Clinical Coordinator is highly engaged in providing direct services to members of the ACT team, mostly in the community.
- This ACT team directly provides psychiatric services and medication management, counseling/psychotherapy, housing support, co-occurring disorder treatment, and employment/rehabilitative services, in addition to case management services. Members benefit when services are integrated into a single team, rather than when they are referred to different service providers.
- The ACT team has explicit admission criteria; the Clinical Coordinator and other staff conduct screenings of referrals with the CC and Psychiatrist having the final decision on admission; and members are admitted to the team at a low rate, helping to support a stable service environment.
- The team was involved in 100% of the ten most recent psychiatric hospital discharges.
- The team values and demonstrates integrating members' natural supports into their care.

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

- Attempt to identify factors that contributed to staff turnover and that support retention. The team experienced a staff turnover rate of 63% during the past two years.
- Identify and resolve barriers to the frequency and intensity of services delivered to members in the community. ACT services should be responsive to member needs, adjusting the frequency of in-person contacts and time spent with members as it relates to member's individual needs and preferences. Higher frequency of contact correlates to improved outcomes for ACT members. ACT services should be delivered in the community, rather than in clinical office settings. ACT teams should deliver services where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural setting.
- Fill the vacant Peer Support Specialist position. Consider receiving technical assistance pertaining to the benefits of having staff with personal lived psychiatric experience on the team.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, there were 10 full-time equivalent (FTE) staff, excluding the Psychiatrist and administrative staff, providing direct services to 100 members. The team has an appropriate member to staff ratio of 10:1. Full-time direct service staff included one Clinical Coordinator (CC), two Nurses, two Co-Occurring Specialists (COS), one Employment Specialist (ES), one Rehabilitation Specialist (RS), one Housing Specialist (HS), one Independent Living Specialist (ILS) and one ACT Specialist (AS).	
H2	Team Approach	1 – 5 4	Members interviewed reported seeing at least two different staff during the last seven days. Staff reported carrying a caseload for administrative purposes only and that all direct service staff provide services to all members on the team. One staff interviewed reported meeting with 70 unique members per week. Another staff reported 97% of members are seen by more than one staff from the team in a typical two-week period. Per review of ten randomly selected member records, for a two-week period, 80% of members received in-person contact with more than one ACT staff.	● Continue efforts to ensure all members on the ACT roster have in-person contact with more than one staff in a two-week period; a diversity of staff allows members access to unique perspectives and the expertise of staff. Ideally, 90% of ACT members have contact with more than one staff in a two-week period
H3	Program Meeting	1 – 5 5	Per staff reports, all members are discussed in the program meeting that is held four days a week, Monday, Tuesday, Thursday, and Friday. All staff are expected to attend on days they are scheduled to work, including the Psychiatrist. The team meets on Wednesdays for clinical oversite.	

			During the meeting observed, all members were reviewed, staff were knowledgeable about members' status, updated the team on last contact, planned contact for the week was discussed, outreach assignments and mechanisms were discussed amongst staff for members that have not been contacted.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimated delivering in-person services to members 50 - 60% of the time. Reported activities include, teaching independent living skills, home visits, medication observation, crisis response, and engages with members when at the clinic. In ten records reviewed there were 23 examples of the CC delivering in-person services in the community and the clinic over a recent month. Services documented included medication observation, teaching independent living skills, psychiatric hospital discharge follow up, and street outreach. Based on a report for a recent month period, the CC provided direct services 47% of the expected productivity of other ACT staff.	● Continue efforts to provide in-person services to members 50% or more of the expected productivity of ACT staff.
H5	Continuity of Staffing	1 – 5 2	Based on data provided, 15 staff left the team in the past two years resulting in a turnover rate of 63%. Per interview and data reviewed with the CC, Nurses were the most difficult to retain with six leaving the team during this time frame.	● If not done already, examine employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention. ACT teams should strive for a turnover rate of less than 20%. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.
H6	Staff Capacity	1 – 5	The team operated at nearly 90% of staff capacity during the prior year. The Peer Support Specialist (PSS) position has been vacant for ten months.	● To ensure diversity of staff, adequate coverage, and continuity of care for

		4		members, fill vacant positions as soon as possible. Timely filling of vacant positions helps to reduce potential burden on staff.
H7	Psychiatrist on Team	1 – 5 5	The team has one FTE Psychiatrist that works four 10-hour days on Mondays, Tuesdays, Thursdays, and Fridays, and attends the program meeting on those days. Staff interviewed reported the Psychiatrist is accessible to the team in person, by phone, email, text messaging, including after hours and on weekends. The Psychiatrist only sees members that are on the ACT team and has no other responsibilities outside of the ACT team. All members interviewed indicated using the ACT Psychiatrist to acquire their medication and reported meeting with the Psychiatrist at least once a month at the clinic. Per review of ten member records for a month period, the Psychiatrist was active with all ten members.	
H8	Nurse on Team	1 – 5 5	The team has two Nurses that work staggered four, ten-hour days. Staff reported that the Nurses are readily accessible to the team by phone, email, in person, and are available after hours. The Nurses attend program meetings on the days scheduled to work. Staff reported one Nurse is the lead at the clinic, but availability to the team is not reduced. The Nurses provide medication education, administer injections, provide medication bubble packs, complete lab draws, monitor symptoms, and conduct blood pressure and routine blood sugar checks to the members. Members interviewed reported meeting with the Nurses weekly to once every three months at the office.	

			Per review of records, the Nurses were active with seven out of ten members at the office in the month period reviewed, including one Nurse responding to a phone call with a member in crisis.	
H9	Co-occurring Specialist on Team	1 – 5 5	The ACT team is staffed with two Co-Occurring Specialists. One recently joined the team in August 2022 and per resume provided, has over one year of experience working with individuals with a serious mental illness (SMI). The second Co-Occurring Specialist joined the team in November 2021 and is a Licensed Associate Substance Abuse Counselor (LASAC) that receives clinical supervision from clinically licensed agency staff twice a month for one hour. Per resume provided this staff has at least one year of providing substance use treatment to adults and co-facilitated intensive outpatient program groups. Per training records provided, both Co-Occurring Specialists completed Narcan, substance use treatment, and the stages of change trainings.	• Ensure both Co-Occurring Specialists receive regular training and clinical supervision, as needed, in providing treatment to members with co-occurring diagnoses.
H10	Vocational Specialist on Team	1 – 5 4	The team has two Vocational staff. The ES joined the team in February 2020. Training records provided for the past two years show the ES completed 2.5 hours of Employment and Rehabilitation training, and per resume has over one year of experience in assisting members with a SMI find and retain employment in integrated work settings. The RS joined the team in May 2022. Per interviews, and review of training records and resume, the RS has less than one year of experience and .5 hours of relevant training supporting individuals in rehabilitation or employment services.	• Ensure that both vocational staff receive regular training in assisting people diagnosed with SMI find and retain employment in integrated settings. • Provide training to the RS on how to support members to seek, obtain, and maintain employment in an integrated work setting. Consider providing supervision to support skill development during this first year in the role.
H11	Program Size	1 – 5 5	At the time of the review, the team was composed of 11 staff, an adequate size. There is one vacant position, the PSS.	

O1	Explicit Admission Criteria	1 – 5 5	Staff reported members are referred by the Regional Behavioral Health Authority (RBHA), other teams within the agency, and other providers. The CC is primarily responsible for screening potential members, although other staff sometimes conduct screenings, utilizing the *Mercy Care ACT Admission Criteria* within 48 hours of receipt of the referral. Potential members are provided information about ACT services during the screening. Together the CC and Psychiatrist make the final determination for new admissions to the team. The ACT team has a clearly defined target population. Staff reported two instances when the team felt pressured to admit members to the team, however, those members did meet criteria after review of their charts.	
O2	Intake Rate	1 – 5 5	Per data provided, and reviewed with staff, the team has an appropriate rate of admissions with less than six members per month admitted to the team. The month with the highest rate of admissions in the last six months was July with three new members added to the team roster.	
O3	Full Responsibility for Treatment Services	1 – 5 5	In addition to case management, the ACT team provides psychiatric and medication management services, psychotherapy/counseling, co-occurring disorders treatment, housing support, and employment and rehabilitation services. All members interviewed reported services they receive are only provided by the ACT team. It was reported seven members are receiving psychotherapy/counseling from the ACT teams LASAC, and that no members are receiving counseling services from brokered providers. Co-occurring disorders treatment is provided by the	

			Co-Occurring Specialists on the ACT team, and no members are engaged in treatment outside the team. Evidence of psychotherapy and co-occurring disorders treatment provided by the team was documented in records reviewed. Staff reported approximately eight members reside in settings where ACT team services are duplicated. Several members reside in peer run housing; however, support is provided by the ACT team and members are not required to attend groups or engage in activities such as day labor to reside at those locations. In records reviewed, evidence of housing support provided by the ACT team was documented. Some members interviewed reported residing in "group homes" or shared housing, however reported ACT staff provide all services to them. Staff reported four members are working and one member is receiving employment support from a brokered provider. For all other members, employment and rehabilitation supports are provided by the team including resume building, job search, interview skills including appropriate attire, eye contact, and handshakes. Staff reported transporting members to interviews when requested and offer ongoing support to members to maintain employment in the community. Records reviewed showed evidence of staff engaging members in conversation related to meaningful activities, and groups offered at the clinic, however, employment engagement or support was not observed other than in treatment plans. Two members interviewed reported ACT	

			team staff assisting them with finding a job in the community.	
O4	Responsibility for Crisis Services	1 – 5 4	The ACT team provides 24-hour crisis response services to members, rotating on-call weekly. There are two backup on-call staff including the CC. When staff need to respond to crisis calls in the evening, both the on-call and one backup on-call staff will go into the community together for safety purposes. The ACT team provides members with an *ACT 1 Meet your Team* handout that includes the ACT 1 crisis line, all staff names, contact information, and titles including a synopsis of what each ACT team member's role entails. Three members interviewed reported familiarity with the ACT teams' on-call number. Two members reported when needing assistance, they would call the local crisis line or 911 to be connected to staff from the ACT team.	• Ensure members are aware of the ACT team's after-hours phone number so that members have direct access to ACT staff, rather than be filtered through another agency before talking with team staff. Some teams assist members by programming the on-call number into member phones. Other teams also provide contact sheets to natural supports to support reaching out to the team rather than community crisis lines or emergency services.
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff indicated the team is directly involved in member psychiatric hospital admissions. When a member is experiencing an increase in symptoms or in crisis, the member is asked to meet with the Psychiatrist either at the clinic or by phone during business hours. After hours, the Psychiatrist will coordinate with staff and will assess the member by phone. If it is determined the member needs inpatient treatment, staff will transport the member and remain with them throughout the intake process. The team reports scheduling a staffing within 24 - 48 hours of admission which includes the member, inpatient team, and natural supports. The team visits in-person with the member every 72 hours. For inpatient providers not permitting outside visitors on the unit, the team will complete phone calls with the inpatient team and videoconferencing with the member.	• 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 aid them during the admission, especially when members have a history of seeking hospitalization without team support.

			Diverse staff are assigned hospital coordination on Mondays, Wednesdays, and Fridays. The ACT team Psychiatrist completes doctor to doctor coordination weekly with the inpatient treating provider. When members self-admit to psychiatric hospitals, staff reported the RBHA notifies the team of the admission within 24 hours to begin coordination of care. In records reviewed, one member was psychiatrically hospitalized for several months; evidence of the team coordinating care with the inpatient team and meeting with the member was observed every 2 - 3 days, including updating the member's service plan treatment goals. In another record, the member's natural support reported on the member's increased symptoms, and the member was assessed by the Psychiatrist the following day to determine if the member needed inpatient or outpatient treatment. According to the data provided and staff interviews, the team was involved in seven out of the ten most recent psychiatric hospital admissions. These admissions occurred over a two-month period. Two members self-admitted and one was petitioned by law enforcement.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Based on data provided, staff interviews, and record reviews, the ACT team was involved in 100% of the last ten psychiatric hospital discharges. Staff interviewed reported that when members are ready for discharge, the ACT team will coordinate with natural supports on the discharge plan, and ACT staff will typically transport the members to the clinic or their residence. For members that have their own	• Ensure the team delivers post psychiatric hospital follow up services and supports as described during interviews.

			vehicles at the facility, ACT staff will meet the member at discharge ensuring the member has everything needed such as medications and will obtain discharge paperwork from the inpatient team. The team follows a five day follow up protocol with members, connecting with them at the clinic or the member's home. Members are scheduled with the Psychiatrist and Nurse within 48 hours of discharge and for members that are not easily engaged with the team, the team transports them to the clinic to be seen immediately upon discharge. Diverse staff are assigned during the program meeting to contact the member for five day follow up. Per member records reviewed, evidence of one member was discharged from an inpatient setting by ACT staff and transported to the clinic, then to the member's residential placement. The member was seen by the Psychiatrist, Nurse, and Primary Care Physician the following day of discharge. The ACT team saw the member for four consecutive days at the member's placement and at the clinic. Documentation for the fifth day of follow up was not noted in the record, however, there was documentation of coordination of care between the ACT staff and residential staff concerning the member's medications.	
O7	Time-unlimited Services	1 – 5 5	Data provided to reviewers showed that the ACT team graduated one member in the last 12 months. The team had a total of five members that left the team in the last year.	

			Staff interviewed reported that the team anticipates graduating three members in the next 12 months. The team measures readiness for graduation and stepping down to a supportive level of care by medication and appointment adherence, housing stability, independent living skills, and no recent hospitalizations or crisis interventions.	
S1	Community-based Services	1 – 5 2	Staff interviewed reported that 80% of in-person contacts with members occur in the community. However, the results of ten randomly selected member records reviewed show staff provided services a median of 28% of the time in the community. Three of the ten records reviewed showed no contacts in the community in a month period reviewed. Three members interviewed reported connecting with staff at the clinic more so than in the community.	• Increase the delivery of services to members in their communities. Evaluate what clinic-based activities can transition to occur in members' communities. Optimally, 80% or more of services occur in members' communities. Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts. • Ensure all staff engage members in the community at a similar level as what was reported by staff interviewed.
S2	No Drop-out Policy	1 – 5 5	According to data provided, the team retained 97% of the members in the last 12 months. The ACT team identified three members that were closed due to declining the intensity of services offered.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reported that when the team loses contact with members, the CC assigns one staff each day of the week to complete outreach efforts. Outreach is conducted four times a week for eight weeks, following the guidelines of the *ACT Outreach and Engagement Policy*. Staff interviewed consistently provided explanation of the team's approach to outreach and engagement efforts including going to the member's last known address, where the member is known to hang out, shelters, and reaching out to jails, hospitals,	• If members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Consider peer review of documentation to ensure efforts are accurately included in member records including letters, phone calls and contact with formal and natural supports.

			medical examiner's office, natural supports, payees, and probation officers. Based on records reviewed, street outreach efforts by staff were documented including specific cross streets, shelters, attempted home visits, and attempted phone calls to the members. However, records lacked assertive efforts of outreach and engagement per the teams described approach and policy. Engagement and outreach efforts were documented ranging from 5 – 16 days.	
S4	Intensity of Services	1 – 5 3	Per review of ten randomly selected member records for a month period before the fidelity review, the median amount of time the team spends in-person with members per week, is 78.25 minutes. The highest member record reviewed indicated a rate of intensity of 146.5 minutes a week, and the lowest member record reviewed indicated a rate of intensity of 5.75 minutes a week.	● ACT teams should provide an average of 2 hours or more of in-person services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on their individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 3	Of the ten records randomly sampled, ACT staff provided an average frequency of 2.63 in-person contacts to members per week. Three members charts reviewed had four or more in-person contacts a week.	● Increase the frequency of contact with members by ACT staff, preferably averaging 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 different needs/goals and frequency of contact should be determined by those needs and immediacy.
S6	Work with Support System	1 – 5 5	Staff interviewed reported 50 - 60% of members have natural supports. Per data provided 68% of members have a natural support. Reviewers were provided calendars of tracked interactions with natural supports for a month period. Evidence showed the team had contact 1 - 8 times for each	

			member that had a support during that timeframe. Most members' natural supports were contacted by the team four or more times in that period. Based on ten member records reviewed, there were nine natural support contacts documented for four members within the month period reviewed. One member interviewed reported ACT staff speaking with roommates identified as natural supports. Other members interviewed reported opting out of including natural supports in their care. During the program meeting observed natural support contact interactions were reported by the team for 30 members.	
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 3	Per interviews and data provided, 54 members were identified with a co-occurring disorder. Staff said that approximately seven members receive individual co-occurring disorder treatment weekly ranging from 30 - 60 minutes per session. Staff reported sessions are structured around the overarching therapeutic strategies of harm reduction, motivational interviewing, by utilizing cognitive behavioral therapy (CBT), and dialectical behavior therapy (DBT). Calendars for one Co-Occurring Specialist provided to reviewers for the most recent month before the review showed 12 members with a co-occurring disorder received individual co-occurring disorder treatment and most were scheduled weekly. However, when comparing the names on the calendar to the data provided of members with a co-occurring diagnosis disorder, only six were listed on the team's roster.	• Train staff on the *stage wise approach* to engage members in individualized treatment as appropriate, based on their stage of change. Make available ongoing supervision to the COSs or other qualified staff to support efforts to provide individual co-occurring disorder treatment. • Evaluate if COS participation in other duties, such as medication observation, limits their ability to engage or provide individual co-occurring disorder treatment. Consider shifting those duties to other staff if indicated. • Consider recording the service minutes provided for individual co-occurring disorder treatment on member calendars.

			Six of the ten records reviewed were identified by the team as members with a co-occurring diagnosis disorder. Records reviewed for a month period showed few instances of individual services being provided or offered to members with a co-occurring diagnosis disorder. Two of the six members received weekly individual sessions with the COS ranging from 25 – 75 minutes per session.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 4	Staff interviewed reported two co-occurring disorder treatment groups are offered to ACT members weekly. Staff reported approximately 11 -15 unique members attend the groups weekly. A review of the attendance sign-in sheets for the month prior to the review showed 21 unique members attended at least one co-occurring disorder group. A review of records showed ACT staff encouraging members to attend groups at the clinic, although notes did not specify which groups as the team offers other groups. Three member records reviewed showed attendance of at least one co-occurring treatment group in the timeframe reviewed. One of those members was not listed on the co-occurring disorder roster. Another member record showed attendance of eight co-occurring treatment groups at the clinic facilitated by non-ACT staff. Two members that were listed on the group sign-in sheets were also not listed on the co-occurring disorder roster provided to reviewers.	• All ACT staff should encourage members with a co-occurring disorder to participate in treatment groups. Ideally, at least 50% of members diagnosed with a co-occurring disorder attend at least one treatment group monthly.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Most staff interviewed reported supporting members in reducing use of harmful substances and were able to provide examples of tactics used. In addition, staff reported meeting the members “where they are at” in recovery utilizing the	• Continue efforts to ensure the ACT team is knowledgeable of evidence-based practices relating to co-occurring disorders treatment. Provide all specialists with annual training and ongoing mentoring in a

			Integrated Co-Occurring Disorders Treatment model, stages of change, and motivational interviewing. The LASAC provides training and education related to substance use to the ACT team weekly including Integrated Co-Occurring Disorders Treatment, relapse warning signs, stages of change, motivational interviewing, and a review of DBT and CBT interventions. Staff reported members are not referred from the team to peer run substance use programs but will support members that request to attend. One staff reported that they would like if the team could refer to peer run substance use programs as an additional resource for members, however some do not align with harm reduction tactics. According to records reviewed, some treatment plans of members with a co-occurring disorder diagnosis documented how the team would address and support the members in steps toward recovery, and in the members perspective. One record reviewed, showed the member wanting to "learn how to maintain sobriety" per the member's treatment plan, however, was not identified by the team with a co-occurring disorder, nor were interventions on how the team will assist with that goal indicated on the treatment plan.	co-occurring disorders model, such as Integrated Co-Occurring Disorders Treatment, in the principles of stage wise treatment, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Adhering to a co-occurring disorder model within the team can promote continuity in the approaches ACT specialists utilize when supporting members. ● Review with staff to ensure accurate documentation of services on treatment plans. For example, include references to co-occurring disorders treatment by a COS, and staff activities based on the member's stage of change.
S10	Role of Consumers on Treatment Team	1 – 5 1	Staff interviewed stated there are no staff on the team with lived psychiatric experience.	• Ideally, the team is staffed with one or more individuals with personal lived psychiatric experience. Staff with lived experience can fill any role on the team and not limited to the Peer position. Sharing stories of recovery by staff with lived experience can offer members hope.

				• Fill the vacant PSS position. PSSs have specialized training and provide a valuable service to members, members' families, and bring a unique perspective to the clinical team. PSSs provide expertise about symptom management and the recovery process; promote a team culture that supports member choice and self-determination; share their story of recovery and practical experience; and carry out other rehabilitation and support functions of the team.
Total Score:		**115**		

ACT FIDELITY SCALE SCORE SHEET

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

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	2
2. No Drop-out Policy	1-5	5
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	5
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	4
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	1
Total Score	**4.11**	
Highest Possible Score	**5**	