ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 5, 2020

To: Stevie Willis, Clinical Coordinator
Amadu Konteh, MD
Dan Ranieri, CEO

From: T.J. Eggsware, BSW, MA, LAC
Karen Voyer-Caravona, MA, LMSW
AHCCCS Fidelity Reviewers

Method

On January 6-7, 2020, T.J. Eggsware and Karen Voyer-Caravona completed a review of the La Frontera-EMPACT Comunidad Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

La Frontera-EMPACT provides crisis and behavioral health services to children, adults, and families. The agency operates three ACT teams. The Comunidad office, located in downtown Phoenix, houses two ACT teams: Comunidad and Capitol. The Comunidad team is the focus of this review.

The individuals served through the agency are referred to as *clients* or *patients*, but 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 the ACT team meeting on January 6, 2020;
- Individual interviews with the team Clinical Coordinator (i.e., Team Leader), the Rehabilitation Specialist (RS) and Peer Support Specialist (PSS);
- Group interview with the team's two Substance Abuse Specialists (SAS);
- Group interview with two members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of documents, including: the *ACT Team Morning Meeting* log, sample member calendars, Clinical Coordinator (CC) face-to-face service tracking report, resumes and training records for the SASs and vocational staff, substance use treatment resources, individual and group substance use treatment participation tracking, the Regional Behavioral Health Authority (RBHA) *ACT Eligibility Screening Tool*, *ACT Admission Screening*, *ACT EXIT Criteria Screening Tool*, and, *Assertive Community Treatment (ACT) Operational Manual*.

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 is of sufficient size to provide the necessary coverage to the 94 members served. The member-to-staff ratio is about 9:1.
- The team meets four days a week to discuss members. During the team meeting observed, staff contributed by reporting on recent and planned contacts with members, including services delivered in each staff's specialty area.
- The members experienced little staff turnover in the prior two years. System partners should attempt to identify factors on the Comunidad ACT team supporting staff retention that providers struggling to retain staff may be able to adopt.
- The team is available to provide crisis support, is available by phone, can meet members in the community after business hours, and provide weekend coverage. Members said staff provided them with a card with the on-call and specialists' numbers.
- The team maintained consistency and continuity of care for members, with a low admission and drop-out rate for the period reviewed.
- Based on observation of the team meeting, the team monitors and supports members to address their medical issues. During the team meeting, staff discussed coordination with the on-site medical provider for routine care. The Nurse provided education to staff on the need to follow-up with medical care specialists for certain members with chronic and significant health issues.

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

- Evaluate what prevented staff from directly supporting members during hospital admissions. Maintain regular contact with members and their support networks, which may result in the identification of issues or concerns that could lead to hospitalization.
- Shift services from the clinic to members' communities, where the majority of challenges occur, and most services should be delivered. Based on records, some members receive most services in the office, and clinic-based groups are regularly offered to members.
- Monitor documented outreach and contacts with members. Evaluate the team's approach to building rapport with disengaged members. Consider updating the agency website with information on ACT services and contact information for the ACT team.
- Increase engagement with natural supports to an average of four times monthly, enhancing their potential as partners in supporting members' recovery goals. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports. Staff may then be able to advise informal supports on how they can reinforce members' healthy recovery behaviors.
- Evaluate the content of the substance use treatment groups and individual treatment to ensure the use of a co-occurring treatment approach. Provide training, ongoing guidance, and/or supervision to staff in a comprehensive stage-wise treatment model developed for members with co-occurring SMI and substance use diagnoses.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 94 members with 11 staff that provide direct services, excluding the Psychiatrist, resulting in a member to staff ratio of 9:1.	
H2	Team Approach	1 – 5 5	Staff said that most members receive face-to-face contact with more than one staff over a two-week time frame. Based on sample records, 90% of members received face-to-face contact with more than one staff over a two-week period. The team practices a zone contact strategy. Staff rotates contact with members based on each member's location in the service area. A map is posted with staff assignments by segment of the service area. Caseloads are assigned for completion of annual paperwork requirements.	
H3	Program Meeting	1 – 5 5	Per staff report, all members are discussed during the program meeting held four days a week (Monday, Tuesday, Wednesday, and Friday). The Wednesday meeting is extended to allow for more in-depth discussion of members. The Psychiatrist attends team meetings four days weekly. The Nurses and other specialists attend the team meeting on the weekdays they are scheduled to work. Some staff work weekend shifts or are off on certain weekdays. During the meeting observed, all members were discussed. Staff contributed by reporting on recent or planned contact with members, and specialty services provided. Staff discussed: services to aid members to obtain or maintain housing; individual substance use treatment and engagement; and, engaging members to explore employment options. Staff discussed members' medical issues, including coordination of care with the on-site medical	

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			provider. The Nurse delivered education to staff on the need to follow-up with medical specialists for members with significant health issues.	
H4	Practicing ACT Leader	1 – 5 4	The CC reported providing direct services 50% of the time. In ten records reviewed there were examples of CC services over a recent month. During the team meeting, the CC reported on recent and planned contact with members, including community-based services. Based on review of the CC's productivity report, the CC provided direct services just over 25% of the time over a recent month time frame.	• Optimally, the CC's delivery of direct services to members should account for at least 50% of the time.
H5	Continuity of Staffing	1 – 5 5	Based on data provided, four staff left the team in the most recent two-year period, resulting in a turnover rate of less than 17%.	
H6	Staff Capacity	1 – 5 5	The team operated at nearly 96% of staff capacity over the prior year. There was a total of six months with position vacancies. The Employment Specialist position was vacant for three months, an SAS position was vacant for one month, and a staff was on leave for two months.	
H7	Psychiatrist on Team	1 – 5 5	The Psychiatrist works four, ten-hour days. Staff said that the Psychiatrist rarely sees members from other teams at the clinic. The Psychiatrist is the lead for the clinic. Staff estimated that the Psychiatrist's duties in that role account for up to two hours monthly (for a meeting). During the morning meeting observed, the Psychiatrist contributed to discussions on member care. Members reported they meet with the Psychiatrist monthly. Staff reported the Psychiatrist is available for consultation, including after hours if needed, and provides community-based services by meeting with members in their homes. Two examples of Psychiatrist community-based	

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			services over a month period were found in the reviewed records.	
H8	Nurse on Team	1 – 5 5	The team has two full-time Nurses who each work four, ten-hour days. Staff said that the Nurses coordinate care with the medical provider at the clinic. Staff reported the Nurses are accessible for consultation, including after hours if needed. Staff said that one Nurse provides most services at the office, but that both Nurses provide community-based services. The reviewers found two examples of community-based Nurse services in the sample records. Staff said that the Nurses rarely provide services to members served by other teams at the clinic, and neither have duties outside of the team.	
H9	Substance Abuse Specialist on Team	1 – 5 4	The team is staffed with two SASs. One SAS joined the team during September 2016 and is a Licensed Associate Substance Abuse Counselor (LASAC). The second SAS worked with the team in another role before transitioning to the SAS position in May 2019. In addition to time in the positon, the second SAS's resume shows experience on ACT teams as a case manager and Independent Living Skills Specialist. In a prior position, the second SAS provided service in a residential treatment setting, and an aspect of the position included facilitating weekly substance use treatment groups. The second SAS's training record showed a combined six and one quarter hours of training in Integrated Treatment for Co-Occurring Disorders and Integrated Dual Diagnosis Treatment (IDDT), and an eight-hour Motivational Interviewing training.	• Provide the SASs with regular training/supervision in co-occurring treatment best practices so they can cross-train other staff on the team in the adopted co-occurring model and appropriate interventions based on members' stages of treatment.
H10	Vocational Specialist on Team	1 – 5 5	The team employs an RS, with the team since March 2007, and an Employment Specialist (ES) who joined the team October 2019. The ES previously worked for more than a year on	

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			another ACT team as an RS. Staff said that vocational staff attends in-person RBHA facilitated employment service trainings twice annually. A RBHA staff provides on-site vocational training every other month. Training records showed staff participated in training for Disability Benefits 101 (DB101), Supported Employment, and Employment/Rehabilitation.	
H11	Program Size	1 – 5 5	At the time of review, with 12 staff, the team is of adequate size.	
O1	Explicit Admission Criteria	1 – 5 5	Staff said that members are referred by the RBHA, other teams at the agency, or other providers. Staff reported no administrative pressure to admit members to ACT. Staff use the RBHA developed *ACT Admission Screening* and *ACT Eligibility Screening Tool*. The CC or other staff meets with members to complete screenings and to provide information to them about ACT services. The screening information is reviewed with the team to determine if members should be offered to join the team.	
O2	Intake Rate	1 – 5 5	Over the prior six months, the peak member admission rate was two members each month during September and October 2019. There were zero admissions each month during August, November, and December 2019, and, one admission during July 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides case management, psychiatric services, substance use treatment, and counseling is available. Staff said that five members receive counseling through the LASAC on the team and no members receive counseling from brokered providers. A member said that staff is available to help with housing and employment services.	• Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff providing housing support. Educate representatives of partner systems on how ACT staff can provide supported housing services in order to minimize the

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			Based on staff interviews, 6% - 14% of ACT members reside in staffed locations, including treatment settings affiliated with the RBHA's system of care and less formal staffed settings. Some members reside or receive treatment in staffed settings due to guardian decisions, under conditions determined by the Arizona Psychiatric Security Review Board (PSRB), or as a term of Probation. Staff said that members transition off the ACT team after three months in residential treatment. One staff said that about three members receive assistance with housing through another provider. The members appear to have accessed the support independently or through contact with shelter system staff. Staff reported no members receive services through the Division of Developmental Disabilities. Based on staff interviews and the team meeting, the vocational staff engages members to explore employment options or opportunities to increase skills. Records and observation suggest that staff frequently offer an employment group and Vocational Rehabilitation referrals. There were fewer examples of ACT staff offering individualized support to assist members to obtain competitive employment. In one record it was documented that a member voiced their interest in employment and asked for team assistance. The member was scheduled to meet with vocational staff. A specialist contacted an agency to follow-up on behalf of the member in their field of interest. Then, at least two weeks passed before staff addressed employment with the member again. One staff estimated 40% - 50% of members	number of members in staffed settings. • ACT staff should first engage directly with members to support rehabilitation and competitive employment goals rather than refer to outside resources. Offer individualized engagement and assistance. Evaluate the benefit of the employment group or Work Adjustment Training (WAT) through brokered providers. Ensure both vocational staff receive ongoing training in best practices to engage and support members to find and retain competitive employment in integrated settings.

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			receive employment or rehabilitative service through the team. Two staff said the team provides employment or rehabilitation support to about ten to 15 members. Staff reported one to three members receive services (e.g., Work Adjustment Training) with brokered providers.	
O4	Responsibility for Crisis Services	1 – 5 5	Members interviewed confirmed that staff is available after hours. Members said staff provided them with a card with team phone numbers. Staff provided to the reviewers the card that they give to members. The card lists specialist positions, contact numbers and the on-call phone number. Staff reported the ACT team is available to provide crisis services 24 hours a day, seven days a week. The on-call assignment rotates among staff daily. The CC serves as the back-up to the on-call and is available to coordinate with the Psychiatrist and/or Nurse. Two staff work shifts each day on Saturday and Sunday.	• Consider including specialist names with their position on the card provided to members.
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff said that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide services. During office hours, staff attempt to arrange for members to meet with the Psychiatrist for assessment prior to admission. Staff is available after hours to support members in the community or with inpatient admissions. Staff is not allowed to transport members in their personal vehicles. The team shares one agency vehicle. The team also has access to a van, shared with other teams at the clinic. Staff reported that they meet with members within 24 hours of being informed of an admission and every 72 hours thereafter. Staff said that the	• Evaluate what contributed to members not seeking team support prior to self-admissions. • Consider if member treatment plans should be revised to address behaviors and/or circumstances related to self-admissions. • Educate members and their support systems about team availability to support members in their communities or to assist with hospital admissions. • Maintain regular contact with all members and their support networks (both informal/natural and formal). This may result in identification of issues or concerns that could lead to hospitalization, allowing the team to offer additional supports,

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			ACT Psychiatrist attempts doctor-to-doctor consultations with inpatient providers. Based on review of recent members who received psychiatric inpatient treatment, staff found out one to two days after some admissions. The ACT team was directly involved in six of the ten most recent member psychiatric hospital admissions. Four members self-admitted.	which may reduce the need for hospitalization. • Ensure staff has access to resources, such as vehicles, to adequately support members seeking inpatient treatment. Consider tracking if/when services are delayed due to transportation access.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff reported the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* with regard to hospital discharge planning. Staff said that when members are inpatient, staff coordinates with inpatient staff. Staff from the team usually meets members at discharge to provide transportation. Staff said that when members are discharged, they have follow-up appointments with the Psychiatrist and the Nurse within 24 hours. Staff reported that they attempt face-to-face contact with members for five consecutive days after a hospital discharge and two to four times per week thereafter. Staff said that the ACT team was directly involved in most of the ten most recent hospital discharges. One member was inpatient and the team was aware. However, when attempting to visit the member at the setting, staff learned that the member transferred to another setting. The member discharged without team involvement.	• Coordinate with inpatient staff, members, and their supports (both informal/natural and formal) to reinforce the benefits of including the team in hospital discharges.
O7	Time-unlimited Services	1 – 5 5	Staff reported that over the prior year, no members graduated from the team and projected two or three graduates in the upcoming year. Staff uses the RBHA's *ACT EXIT Criteria Screening Tool* to evaluate members for discharge/transition.	
S1	Community-based	1 – 5	Staff reported delivering 75% - 80% of direct	• Increase the delivery of services to

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	Services	2	services in the community. In ten member records, a median of 36% of services occurred in the community over a recent month period. Multiple staff contacts were documented for members during office visits. In ten records, the member who received the highest service intensity and number of contacts with staff received fewer than 22% of services in the community. In ten records, staff frequently documented inviting members to clinic-based groups. Members said that staff meets them equally in the community and office. Some documentation of community-based activities contained general information but not the location or individualized member details.	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. • Document where community-based contacts occur. For example, consider including cross-streets if contact does not occur at the member's home, or a location with an address. • Document individualized information for members who participate in groups.
S2	No Drop-out Policy	1 – 5 5	Based on data provided, no members closed in the 12 months prior to the review due to refusing services, team determination that they could not be served, or leaving the geographic area. One member transitioned to *Navigator* status after a period of no contact. Two members transitioned to ACT services with other providers. Staff said that members who receive residential treatment transition off the team after three months.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff said that when members are not in contact with the team staff attempts outreach for eight weeks. Staff said that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide their outreach. Staff said they coordinate with formal supports (e.g., probation officers, payees), outreach to natural supports, and search for disengaged members at shelters and locations where members have been known to visit in the past. Staff discussed outreach and engagement during the meeting observed.	• Monitor documented outreach and contacts with members. It may be useful to assign a staff to spot-check documentation in member records during the team meeting to confirm recent contacts or outreach efforts are documented. This may enable the team to proactively assign staff to outreach or contact in the event of lapses. • Ensure staff are familiar with the outreach expectations outlined in the *Mercy Care RBHA Assertive Community Treatment*

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			In records, over a month time frame, there were gaps in documented contact and outreach. Over a 12-day time frame the team documented three outreach attempts for one member. Another member received two contacts and two outreach attempts over a nine-day period. After making contact with the member at the office, staff documented one outreach over the following 13 days. Over ten days, one member received one outreach attempt and one office-based contact. After the contact, seven days lapsed until the next office-based contact and then eight days passed until the next contact. An incarcerated member received one attempted visit over a 19-day period. Following release, staff documented two outreach attempts over a ten-day period.	*(ACT) Operational Manual*
S4	Intensity of Services	1 – 5 4	The median weekly intensity of face-to-face service time provider per member was about 95 minutes based on ten records. The average weekly service per member ranged from under 23 to 290 minutes. Four of the ten members received an average of more than 120 minutes service time weekly, but three of those members received the majority of contacts in the office. Some members participate in clinic-based groups with staff who are not on the ACT team. Member participation in those groups was not factored into this report.	• Evaluate how the team can engage or enhance support to members who receive a lower intensity of service. The ACT team should provide members an average of two hours of face-to-face contact weekly. • Ensure staff are trained on appropriate documentation standards so services and service time can be accurately reflected in the members' medical records.
S5	Frequency of Contact	1 – 5 4	In records, there was a median of three weekly face-to-face contacts for ten members. Documented contacts in ten records range from less than once per week to about ten per week. Three members received an average of four or more contacts weekly.	• Seek to balance services delivered to more frequently contacted members and those who staff meet with less often. Optimally, members receive an average of four or more face-to-face contacts a week.
S6	Work with Support System	1 – 5	During the team meeting observed staff discussed engaging members to identify natural supports.	• The team may benefit from further training on strategies to assist members in building

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		3	Staff discussed their recent or planned contact with informal supports for 12 members. One member interviewed said they believed staff makes contact with their family and one member was aware of the authorization process staff follow to involve natural supports. Staff said that the team attempts weekly contact with informal supports. Staff offered varying estimates of members with natural supports, ranging from 11% - 80%. In ten records, over a month period, staff documented a total of 11 contacts with informal supports: seven for one member; two for one member; and, once each for two members. Staff documented in records that they asked members to identify natural supports.	and engaging natural supports. • Educate informal supports about how they can support members' recovery. For example, assist them to identify community-based activities they can engage in with members. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or model use of recovery language.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported that the SASs meet at least monthly with most of the 76 members with co-occurring diagnoses. Some members are incarcerated or have inconsistent contact with the team so there is infrequent individual treatment. Staff said sessions last from 30-60 minutes. The two SASs divide the number of members with co-occurring diagnoses. One SAS reported that they meet with 15 members for individual substance use treatment weekly. The second SAS reported meeting with about 30 members weekly. Data showed eight of the ten members in the record sample having a substance use diagnosis. Examples of individual treatment were documented in records. Over a month period, sessions per member ranged between zero with three members and six contacts with one member. Treatment included discussion of strengths, coping skills, and triggers. Most sessions were around 30 minutes, and the average was about 38 minutes.	• Work to increase the time spent in individual sessions so that the average time is 24 minutes or more across the group of members with co-occurring diagnoses. • Evaluate if SASs sharing in other duties, such as to members who do not have co-occurring diagnoses, limits their ability to engage or provide individual substance use treatment. Consider shifting those duties to other staff.

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			Individual session tracking data provided over a month period showed the number of one-to-one contacts each SAS made with members. Based on the average session in records, and the individual treatment tracking, the SASs provided approximately 15 minutes of substance use treatment weekly on average to members with co-occurring diagnoses.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff said that each SAS facilitates two weekly co-occurring treatment groups. Three groups are held at the office: one on Tuesday and two on Wednesday. The fourth group is held Sunday at ACT affiliated housing where a group of ACT members reside. Staff reported four to five members regularly attend the Tuesday group and six to seven members participate in the Sunday group. Staff reported low participation for the Wednesday groups. Documentation in sample records showed staff inviting members to substance use treatment groups. Two of eight applicable members participated in group substance use treatment over a month period. Based on review of co-occurring treatment group sign-in sheets over a recent four-week time frame, it appears slightly under 16% of ACT members with co-occurring diagnoses attended at least once.	• Staff should continue to engage dually diagnosed members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring group. Staff may benefit from training on strategies to engage members in group substance use treatment. • Consider modifying a group to serve members in earlier stages and a group to serve members in later stages. It should allow staff to adjust their interventions to members in different stages of treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Staff gave examples of harm reduction. Staff supports members to reduce use. Staff works with members to eliminate more harmful substances before focusing on less harmful substances. Some staff said that the team does not refer to Alcoholics Anonymous (AA) or similar groups but one staff said they support members if they are interested and offer to attend with members. Staff identified circumstances when the team might	• Provide ongoing guidance to staff in a comprehensive stage-wise treatment model, ideally, an approach developed for members with co-occurring SMI and substance use diagnoses. This may help the staff to provide consistent service if SASs transition off the team. • If the team elects to continue utilizing the resources provided for review, determine if

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			refer members for medical withdrawal management. Some staff gave examples of substances likely to require that support. In records, seven of eight applicable member treatment plans addressed substance use. The treatment plans seemed to reflect members' goals and included services such as group and individual substance use treatment. During the meeting observed, the SASs referenced individual and group substance use treatment and engagement. Staff identified members' stages of change during the team meeting. Staff uses stage of change to describe member statuses in relation to substance use treatment, as well as activity participation, employment, and housing. Training records showed staff received training for Integrated Treatment for Co-Occurring Disorders and IDDT. Staff said that the team meets for trainings in IDDT led by licensed staff from the ACT team. Some staff appears to be familiar with *stage-wise* treatment. Staff provided a matrix that identifies stage of treatment and interventions. However, other treatment resources provided were not IDDT, an evidence-based practice for members with co-occurring SMI and substance use diagnoses. The SASs draw from: *Living In Balance Moving from a Life of Addiction to a Life of Recovery; SAMHSA Treatment Improvement Protocol (TIP) Series, No. 35; Time-Effective Treatment A Manual for Substance Abuse Professionals; Seeking Safety A Treatment Manual for PTSD and Substance Abuse*. Although there may be beneficial elements	treatment can be tailored to make best use of the materials. For example, consider modifying a treatment group to serve individuals with substance use and history of trauma.

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			of each resource, *Living In Balance* and *Seeking Safety A Treatment Manual for PTSD and Substance Abuse,* these materials were not developed specifically for the population served by the team.	
S10	Role of Consumers on Treatment Team	1 – 5 5	A member and a staff interviewed said a staff on the team has lived experience of recovery from substance use. A staff and another member were unaware of staff on the team with direct lived experience of psychiatric recovery. Other staff said that there is an employee on the team with direct lived experience of psychiatric recovery.	• Ensure member voice is represented. Not all interviewees were aware if there is staff on the team with direct personal lived experience of psychiatric recovery.
Total Score:		**4.32**		

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

7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	3
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	**4.32**	
Highest Possible Score	**5**	