ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: April 26, 2022

To: Stevie Willis, Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On March 15 – 16, 2022, Nicole Eastin and Annette Robertson 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 adults, children, and families. The agency operates three ACT teams, two located at the Comunidad office located in downtown Phoenix and one in Tempe. The Comunidad team is the focus of this review.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. Delivery of telehealth services, including phone only, were calculated for this review, however those totals are not included in calculating scores for those items that measure in-person contact between the ACT team and members. In the State of Arizona, delivery of telehealth services by Psychiatrists is considered as in-person because of the shortage of providers. This review was conducted remotely, using videoconferencing or telephone to interview staff and members.

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

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

- Remote observation of an ACT team program meeting March 15, 2022.
- Individual interview with the Clinical Coordinator (CC).
- Individual interviews with both Substance Abuse Specialists and the Housing, Employment, Rehabilitation, Independent Living, and Peer Support Specialists.

- Individual phone interviews with four 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,* CC's service tracking report, resumes and training records for SAS and Vocational staff, substance use treatment resources, *Comunidad ACT Business Card*, group substance use treatment participation tracking, and excerpts from the Mercy Care ACT manual relating to hospital admission and discharge protocols, *and outreach and engagement*.

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 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 91 members served with a member to staff ratio of 9:1.
- The team, including the Psychiatrist, meets four days a week to discuss members. Multiple staff contribute to the meeting discussion by reporting on recent and planned contacts with members.
- The team operated at nearly 99% of staffing capacity for the last 12 months. The team includes a Psychiatrist, two Nurses, two Vocational staff, staff with psychiatric lived experience, and two SAS's. Staff work four, 10-hour days a week, and rotate on-call duties daily, all which was highly supported by staff interviewed.
- In the past 12 months, this team has maintained consistency and continuity of care for members, as evidenced by maintaining low admission and drop-out rates.
- The team is available to provide crisis support by phone, in the community, after business hours, and weekend coverage. Members reported having a card with the on-call number and specialists' numbers.
- The team was involved in 100% of the ten most recent psychiatric hospital discharges.

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

- Increase contact, members on the ACT team should average four or more in-person contacts a week and those contacts should be with more than one staff over a two-week period.
- Evaluate what prevented staff from directly supporting members during hospital admissions. One half of the hospital admissions reviewed resulted in members seeking hospitalization without the ACT team knowledge or involvement. Work with these members to ensure that they are aware the team can support when seeking hospitalization.

- Increase engagement with natural supports. Engaging with natural supports can boost 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.
- Provide ongoing training to all staff on the stage-wise treatment approach and strategies to engage members in individual and/or group treatment. Ensure service plans are written in members point of view and reflect individual goals related to services provided and needed.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team serves 91 members with 10 direct service staff, excluding the Psychiatrist. The team has an appropriate member to staff ratio of 9:1.	
H2	Team Approach	1 – 5 3	Staff interviewed reported using a rotating assignment of regions every two weeks to ensure members are exposed to diversity of staff. The medical staff are not included, nor is the licensed SAS. Per the ten randomly selected member records reviewed for a month period, a median of 60% received in-person contact from more than one ACT staff in a two-week period. Of those ten records, two members were incarcerated at the time of the review, and one member was on outreach with the team. One incarcerated member declined attempts by one staff to be seen. Another member had no contact with the ACT team, however, met with non-ACT clinic staff for benefit related assistance in the month period reviewed. Members interviewed reported seeing more than one staff in a two-week period.	● Continue efforts to ensure at least 90% of members on the ACT roster have in-person contact with more than one staff in two weeks; a diversity of staff allows members access to unique perspectives and the expertise of staff. ● For any members declining engagement efforts while incarcerated, or otherwise, support the use of diverse staff to provide members alternative staff with whom to connect.
H3	Program Meeting	1 – 5 5	The team meets virtually through a videoconferencing platform four days a week to review all members on the roster which is a change since the last fidelity review. All staff are expected to attend the meeting on days scheduled to work. One of the four days, the team meets to discuss member needs more in-depth and update treatment plans. The Psychiatrist attends the program meeting four days a week and during the meeting observed, provided direction to the team for next steps with members. Staff reported on	

			members' stage of change for those with a co-occurring disorder and spoke about members' stage of change relating to their engagement and treatment goals.	
H4	Practicing ACT Leader	1 – 5 3	The CC reports providing direct in-person services 50% of the time. In ten records reviewed there were three examples of the CC delivering services over a recent month. Based on review of the CC's productivity report, the CC provided direct services 16% of the time over a recent month time frame. There were no phone or telehealth services documented in any of the records reviewed, however, the productivity report did identify at least 20 phone contacts. *The fidelity tool does not accommodate delivery of telehealth services.*	● ACT CCs should dedicate a minimum of 50% of their time providing direct, in-person services to members. ACT leaders that have direct clinical contact with members are better able to model appropriate clinical interventions and remain in touch with the members served by the team.
H5	Continuity of Staffing	1 – 5 4	Based on data provided, five staff left the team in the past two years, resulting in a turnover rate of 21%. Two Independent Living Specialists left the team during this time. All ACT specialists work four, ten-hour days, except one Substance Abuse Specialist. Staff reported working four days a week, rotating on-call duties daily, virtual team meetings, and supportive leadership has been helpful to staff in their roles and preventing burnout.	● System stakeholders may want to consider evaluating the team's leadership approach and how it impacts staff turnover. Of interest may be the implementation of a compressed work week and rotating on-call duties daily.
H6	Staff Capacity	1 – 5 5	The team operated at nearly 99% of staff capacity during the prior year. The Housing Specialist position was vacant for two months.	
H7	Psychiatrist on Team	1 – 5 5	The Psychiatrist on the team works four, ten-hour days. Staff reported the Psychiatrist only sees members assigned to the team and is readily accessible to the team including after hours if	

			needed. Staff stated the Psychiatrist is very involved in member care, providing supervision to the team including education on diagnoses, symptoms, medications, and side effects. Members interviewed reported meeting the Psychiatrist monthly in the office and through telemedicine (videoconference).	
H8	Nurse on Team	1 – 5 5	The team has two full-time Nurses that work staggered four, ten-hour days. Staff reported the Nurses are readily accessible to the team by phone, email, in person, and are available after hours. The Nurses attend program meetings with the team on the days they are scheduled to work. To members, the Nurses provide medication education, administer injections, draw labs, follow up with members health concerns, monitor for increased symptoms, provide medications, and complete primary care physician, specialist, and hospital coordination. It was reported the Nurses provide 20% of services in the community.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team is staffed with two full-time Substance Abuse Specialists (SAS). One SAS joined the team in 2016 and is a Licensed Associate Substance Abuse Counselor (LASAC). The second SAS has been in the role since May 2019. In the past two years, training records provided showed one SAS completing nearly 20 hours of training and subjects included *motivational interviewing*, *IDDT*, co-occurring disorders assessment and functional analysis, *trauma-informed care*. The second SAS has 3.50 hours of *Motivational Interviewing Intermediate* and reported the team recently attended a four-hour Integrated Dual Disorders Treatment training.	

H10	Vocational Specialist on Team	1 – 5 5	The team has two full-time Vocational Staff. The Rehabilitation Specialist (RS) joined the team in 2007 and the Employment Specialist has been on the team since 2019. Training records provided for the past two years show the RS completed over four hours of Supported Employment courses and a motivational interviewing training. The ES training records show completion of part of a Supported Employment series and motivational interviewing.	
H11	Program Size	1 – 5 5	At the time of the review, with 11 full-time staff, the team is of adequate size. There is one vacant position, the ACT Specialist.	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported members are referred by the Regional Behavioral Health Authority (RBHA), other teams from within the agency, and other providers. The CC or other ACT team staff meet with the potential members to complete screenings and provides information about ACT services. The team uses the *Mercy Care ACT Admission Criteria*. The screening information is reviewed with the Psychiatrist who makes the final decision if the member is appropriate for the team. The team schedules a transfer staffing with the member and the entire ACT team once accepted during which the Psychiatrist completes a psychiatric evaluation. The team provides new members with the *Comunidad ACT Business Card* with team contact numbers as well as the on-call after hours number.	
O2	Intake Rate	1 – 5 5	Per data provided, and reviewed with staff, the team has an appropriate rate of admissions. The month with the highest rate of admissions during the past six months was November with four new members added to the team roster.	

O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services, substance use treatment, counseling/psychotherapy, and housing support. Staff reported three members on the team receive counseling through the LASAC on the team and no members are receiving counseling from brokered providers. Two members were reported to be receiving substance use treatment services outside the team and most housing services are delivered by the team. Based on interviews, the team's vocational staff engages members to explore employment opportunities in the community. Records reviewed showed evidence of staff engaging members in conversation related to employment, meaningful activities, and groups offered at the clinic. One record reviewed showed the ES assisting a member with medical leave paperwork to submit to the employer. At the time of the review staff report assisting approximately 15 members with employment goals, 15 are working, and of those, seven are receiving Supported Employment and/or Work Adjustment Training (WAT) services through a brokered provider outside the ACT team. One member interviewed reported receiving employment services through a brokered provider.	● ACT services should be fully integrated into a single team, with referrals to external providers only for specialty cases, such as court ordered services. ● The ACT team, and vocational staff in particular, may benefit from training or consultation on the concept of *zero exclusion* as well as the impact and benefits of work. Competitive employment is recognized as both a motivation for and a marker of recovery. An unsuccessful job outcome can be an opportunity to reflect on lessons learned and exploration of the consequences of personal choices rather than simply a failure or an indication of disability. Ideally, ACT teams are advocating for the member's stated readiness as opposed to steering to paid and unpaid work activities. This can discourage hope and momentum to active engagement in recovery services.
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the ACT team is available to provide crisis services 24 hours a day, seven days a week. Staff provided a copy of the business card given to members and natural supports that lists the on-call number, as well as numbers for each of the specialist positions and the CC.	

			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. If the on-call is required to contact 911 for medical emergencies, the staff will meet the paramedics at the member's location. The team had last responded in-person the month before the review. Members interviewed reported having the on-call number and ACT staff numbers, and the ability to contact the ACT team in the evenings and weekends. One member reported using the on-call number in the past to connect with an ACT team staff on the weekend.	
O5	Responsibility for Hospital Admissions	1 – 5 2	Based on data provided and reviewed with staff, the team was directly involved in three of the ten most recent member psychiatric hospital admissions. Staff reported during business hours if a member is experiencing an increase in symptoms the team will bring the member to the clinic to be assessed by the Psychiatrist, and if the recommendation is for inpatient care, the team will ask the member which hospital they prefer. The team will transport the member, coordinate with the inpatient social worker providing a medication flow sheet, face sheet, and ACT team contact information. Staff wait with the member until admitted at facilities that allow staff to stay. When the team petitions or amends a member's court ordered treatment, staff will coordinate pick-up and provide the member's medication sheet and face sheet. In one member record, the Psychiatrist assessed for increased symptoms, the court ordered treatment (COT) was amended by the team while the member was at the clinic, and pick-up coordination was completed.	● Evaluate what contributed to members not seeking team support prior to self-admission. Consider if member treatment plans should be revised to address behaviors and/or circumstances related to self-admissions. 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. ● 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. This may result in early identification of issues or concerns that could lead to hospitalization allowing the team to offer additional supports which may result in a reduced need for hospitalization. Providing team information to external sources, i.e., law enforcement, and informing of the availability of the

			Five members admitted themselves to a psychiatric facility for treatment without the team's knowledge. Law enforcement were involved in at least two other instances of the team not being directly involved.	team to provide services after hours in the community may improve coordination and prevent admissions without team involvement.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported the team is involved in all psychiatric hospital discharges. As soon as the member is admitted to a psychiatric inpatient facility discharge planning begins. The team coordinates with the inpatient team within 24 hours of admission and attends staffing's by videoconference or phone on a weekly basis. The team coordinates member care with natural supports. Upon discharge, the team follows a five-day discharge protocol and attempts to see the member in-person or by phone for the first week after discharge. The member is scheduled with the Psychiatrist and Nurse within 72 hours of discharge and the team schedules the member with their primary care physician. A review of the ten most recent inpatient psychiatric discharges with the CC indicated that the ACT team was directly involved in 100%.	
O7	Time-unlimited Services	1 – 5 5	Staff reported that over the past year, three members graduated from the team and projected fewer than 5% will graduate in the next year.	
S1	Community-based Services	1 – 5 4	Staff reported 80% of their time is spent providing direct services to members in the community. In ten member records, a median of 63% of services occurred in the community over a recent month period. In ten records reviewed, a member with the highest service intensity and number of contacts with staff was seen in the community	• ACT teams should deliver 80% or more of their contacts in the community where staff can directly assess member needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting.

			almost 95% of time. Most documented community visits in records reviewed were at members' home or members were attending ACT team groups. However, documentation lacked identification of the location of some groups. Staff also reported identifying a group held in the clinic parking lot as "community based". Of the members interviewed two reported seeing staff at the clinic and in their home, while two others reported seeing staff mostly at the clinic.	• Document individualized information for members that participate in groups and ensure the location coincides with the service location documented. • Consider providing group activities in a community setting where members interact with other persons in the natural community environment, rather than sheltered clinic settings.
S2	No Drop-out Policy	1 – 5 5	Based on data provided, in the 12 months prior to the review, the team retained 98% of the members on the team. No members were closed due to refusing services or because the team determined they could not be served. Two members left the geographical area with a referral for services in a new location. One member left the geographical area without a referral and one member was transitioned to Navigator status after a period of no contact.	
S3	Assertive Engagement Mechanisms	1 – 5 3	The team reported that when members are not in contact with the team, outreach is completed four times a week for eight weeks, following the guidelines of the RBHA's outreach *policy*. Staff interviewed consistently provided explanation of the team's approach to outreach and engagement efforts including the member's last known address, where the member is known to hang out, shelters, reaching out to jails, hospitals, medical examiner's office, natural supports, payees, and the RBHA for any insurance claims filed outside of the ACT team. During the program meeting observed, staff provided updates on outreach efforts on multiple members. The Psychiatrist was observed informing the team that when members	• Ideally, outreach should be carried out by multiple ACT staff, drawing from motivational interviewing skills, allowing members a diverse group with whom to connect. For any members declining engagement efforts while incarcerated, or otherwise, support the use of diverse staff in an attempt to provide the member an alternative staff with whom to connect. • In addition to initiating outreach following missed appointments, consider other instances when outreach/engagement should occur. For example, consider initiating more assertive outreach when there are lapses in contact with members.

			are located in the community, the Psychiatrist will complete a visit with the staff and member via telehealth. Two member records showed staff outreaching members in the community. Staff documented detailed outreach including specific cross streets, bus stops, grocery stores, gas stations, libraries, shelters, hospitals, community service locations, and parks. Evidence in records showed outreach by staff did locate one member in the community and two others that were in jail. However, records lacked assertive efforts of outreach and engagement per the team's described approach and policy. One member record reviewed showed the member was at the clinic three separate times meeting with the non-ACT staff and had one attempted phone call by ACT staff, though was not seen in person by any of the ACT team staff in the month period reviewed. Two members were incarcerated and when staff visits were declined, the team continued sending the same staff, nor were the attempts assertive in nature.	
S4	Intensity of Services	1 – 5 4	Per a review of ten randomly selected member records during a month period before the fidelity review, the median amount of time the team spends in-person with members per week is 101.50 minutes. The average weekly service per member ranged from 0 to 396.75 minutes. Five of the ten members received an average of more than 100 minutes service time weekly. Documentation of services delivered in some records reviewed lacked corresponding detail of	● 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 in-person contact weekly. ● Ensure staff are trained on appropriate documentation standards so that services and service time can be accurately reflected in the members' medical records.

			the actual services delivered correlating to the length of time of the service. Some documentation overlapped services delivered by the same or another ACT staff.	
S5	Frequency of Contact	1 – 5 3	In records reviewed, there was a median of 2.38 weekly in-person contacts for ten members. Contacts range from less than once per week to about ten per week. Three members received an average of four or more contacts weekly. Two members interviewed reported seeing staff once a week and one member reported seeing staff three times per week. Only two records had documentation of phone contact by the team, once each. *The fidelity tool does not accommodate delivery of telehealth services.*	● Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to provide ongoing support. Improved outcomes are associated with frequent contact. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. Those contacts should be individualized and align with treatment goals identified in member plans. ● Increase the frequency of contact with members, preferably averaging four or more face-to-face contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. ● Ensure staff on the team are trained and supported in documenting all contacts with members, including phone, text, and email.
S6	Work with Support System	1 – 5 1	Per records reviewed there were four contacts documented with natural supports within the month period reviewed. There was evidence of staff having conversations with members regarding the importance of having natural supports involved. Staff reported a range of 20 - 75% of members having a natural support and staff making weekly contact with those supports. Staff reported communicating with natural supports about resources in the community, programs available to members, medication changes, appointments, how to support members,	● Increase contacts with informal supports to an average of four per month for each member with a support system. As much as possible, contacts with informal supports should occur during the natural course of delivery of services provided to members, but may occur by phone, email, or text. ● Educate informal supports on measures that 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

			and overall member status. Natural supports are tracked on member calendars during the program meeting. Two members interviewed reported the team has contact with their natural supports, two others reported the team can talk to their natural supports if there is a need.	supports tips on how to reinforce healthy recovery behaviors. ● Encouraging clinic-based activities may limit members' opportunities to develop natural supports and social networks. As the community reopens and vaccination rates improve, consider opportunities for member engagement supporting identities and recovery visions outside that of behavioral health recipient.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported that the SAS's meet at least monthly with approximately 60 of the 71 members identified with a co-occurring disorder. One SAS reported meeting with 30 members three to four times a week for a total of 30 - 45 minutes. The second SAS reported meeting with 30 members in the last month for 30 - 60 minutes. Staff reported sessions are structured around SAMHSA materials, IDDT, harm reduction, and motivational interviewing strategies. Resources utilized by staff include *Living in Balance and Seeking Safety, SAMHSA Integrated Treatment for Co-Occurring Disorders,* and *Substance Abuse and the Stages of Change.* Of the ten charts reviewed, nine members were listed on the co-occurring diagnosis roster provided by the team. Evidence showed five of the nine members received individual substance use treatment in a month period reviewed. Sessions ranged between 25 - 56 minutes. Documentation identified recovery focused discussions relating to harm reduction, relapse triggers, recovery action plans, and included motivational interviewing techniques. Four member records did not have	● Train staff on strategies to engage members in individualized treatment as appropriate, based on their stage of change. ● Make available ongoing supervision to SASs to support efforts to provide individual substance use treatment that is based in a co-occurring disorders model.

			substance use treatment engagement or individual sessions documented.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	Staff reported that each SAS facilitates two weekly co-occurring disorders treatment groups for ACT members only, ranging from 20 - 28 unique members in attendance a month. These groups occur at the clinic and in the community. One SAS focuses on action and maintenance stages of change while the other focuses on pre-contemplation and action stages of change. Based on review of co-occurring treatment group sign-in sheets, over a recent four-week time frame, 27% of ACT members with a co-occurring diagnosis attended at least one. Two of nine applicable sampled members participated in group substance use treatment over a recent month period. Documentation in sample records showed ACT staff inviting members to groups, although did not indicate substance use treatment groups specifically.	● Continue efforts to engage 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. ● Co-occurring treatment groups work best when based in an evidence-based practice (EBP) treatment model. Consider structuring groups around proven curriculum for optimal impact for this specific population, serious mental illness and substance use disorder diagnoses.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Staff support members in reducing use of harmful substances, gave examples of harm reduction tactics, and recognized improved outcomes because of the use of it. Staff do not refer members to peer run substance use programs but will support members that request to attend. When members request detoxification services, the team will refer them to local resources. Two of the nine members sampled reflected group and/or individual substance use treatment goals in service plans. Some service plans indicated the teams' assessed needs, goals, objectives, and interventions related to substance use; however individualized substance use treatment were not	● If not done so already, provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Dual Disorders Treatment, in the principles of a stage-wise approach to interventions, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new or less experienced staff and further improve skills and understanding of staff with longevity. Identifying a co-occurring disorder model that the team adheres to can promote continuity in the

			listed as part of the service plan. Some plans referenced "maintaining sobriety" but was unclear if this reflected the member's voice or clinical jargon. Some members listed on the COD roster provided to reviewers do not have substance abuse diagnosis listed in their record. One member sampled was not listed on the COD roster provided, although the members record indicated an alcohol related disorder. Staff reported the LASAC, and the SAS provide training to the team, as does the ACT Manager. SAS staff reported receiving supervision weekly by the CC and ACT Manager. It is unclear what their qualifications are to provide clinical supervision. Some staff on the team are familiar with stage-wise treatment while others are not. Training records for VS staff did show motivational interviewing, trauma informed care, and co-occurring disorders online trainings were completed in the past two years.	approach that ACT specialists use when supporting members in their recovery. • Review with staff to ensure accurate documentation of services provided on member treatment plans. For example, referencing substance use treatment services to be provided by an SAS, and staff activities, i.e., stage-wise approach, based on member's stage of treatment. Consider discussion of example service plans during group supervision or team meetings. • Ensure all staff providing substance use treatment receives necessary training and appropriate supervision in an evidence-based integrated substance use treatment approach.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has at least one staff with psychiatric lived experience. The staff uses their lived experience of psychiatric recovery to educate the team on approaches to use with members and encouraging additional services to engage members and natural supports. During new member staffing's, the staff with psychiatric lived experience explains their role and how they can support the member in their recovery. Of the members interviewed, only one reported knowing of staff on the team with lived experience and had shared their story of recovery with the member.	
	Total Score:	**116**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	4
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	5
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	2
6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.14**	
Highest Possible Score	**5**	