ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 9, 2022

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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. ACT is an evidence-based practice (EBP).

Method

On September 27 - 28, 2022, Fidelity Reviewers completed a review of the Copa Health West Valley 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.

Copa Health operates several outpatient centers, offers employment related services, day program activities, integrated health, and residential services. Individuals served through the agency are referred to as *clients* and *members*. For the purpose of this report and for consistency across fidelity reports, the term "member" will be used.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing 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 on September 27, 2022.
- Individual video conference interview with the Clinical Coordinator (CC).
- Individual video conference interviews with both Co-Occurring Specialists, the ACT Specialist, and the Peer Support Specialist.

- Individual phone interviews with three 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*; resumes and training records for Vocational and Co-Occurring Specialists' staff, sign in sheets for co-occurring disorder treatment groups for Clinical Coordinator productivity report for the month of August; *West Valley ACT Brochure, 8-Week Outreach,* 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 ACT CC is highly engaged in providing direct services to ACT members in the community.
- The ACT team has explicit admission criteria; the CC conducts the screening, the ACT team discusses the potential new member for appropriateness, and the ACT Psychiatrist has the ultimate decision about membership.
- The ACT team has 24/7 crisis management services available to the members. There was detailed evidence of this service delivery in the records reviewed.
- The ACT team provides time-unlimited services to members, evidenced by retaining 97% of the caseload over the past 12 months. Staff indicated an expectation of a low graduation rate in the next 12 months.

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

- The ACT team experienced a staff turnover rate of 71% during the past two years. Identify factors that contributed to staff turnover and implement protocol that supports retention.
- The ACT team had both Nurse positions vacant at the time of the review. The Nurse position was one of the positions with the highest turnover rate, 30%. Work to hire Nurses with experience in serving individuals with Severe Mental Illness (SMI) and identify strategies to retain staff in this position.
- Increase the frequency and intensity of services delivered to members. ACT services should be responsive to member needs, adjusting in intensity and frequency as it relates to members' individual needs and preferences. Higher frequency of contact correlates to improved outcomes for ACT members.

- Few members with a co-occurring disorder attend the substance use treatment groups provided by the team. Staff should continue to engage members with a co-occurring disorder to participate in group substance use treatment, as appropriate, based on their stage of treatment.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, there were seven full-time equivalent (FTE) staff, excluding the Psychiatrist and administrative staff, providing direct services to 96 members. The team has a member to staff ratio of 14:1. Full-time direct service staff included one Clinical Coordinator (CC), two Co-Occurring Specialists (COS), one ACT Specialist (AS), one Housing Specialist (HS), one Employment Specialist (ES), and one Peer Support Specialist (PSS).	• Ensure necessary staffing for a member to staff ratio of no greater than 10:1, excluding the Psychiatrist and administrative staff. • Continue efforts to hire and retain experienced staff. Small caseload size ensures adequate intensity and individualization of services and minimizes the potential burden on staff.
H2	Team Approach	1 – 5 3	Staff reported having an assigned caseload for administrative purposes only and estimated 95% of members see more than one staff from the team in a two-week period. Based on interviews with staff it is unclear if the team utilizes a rotating strategy to ensure members are seen by different staff weekly. One staff indicated seeing the same members consistently in an assigned region. Members interviewed indicated meeting with different staff members every week. Per review of ten randomly selected member records for a two-week period, 40% 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. • Consider a strategy utilized by other teams by assigning geographic areas to specialists that rotate daily or weekly to ensure members are engaging with different staff from the ACT team frequently.
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 through Thursday. All staff are expected to attend on days they are scheduled to work. The Psychiatrist attends every meeting virtually.	

			During the meeting observed, all members were reviewed. Staff were knowledgeable about members' status, and recent contacts with members and formal/natural supports were discussed. Stages of change were identified for each member with a co-occurring disorder diagnosis that a COS had contact with since the last program meeting. Members' upcoming appointments and planned contact for the week was discussed, including members on outreach.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimated delivering in-person services to members at least 50% of the time. The CC reported conducting medication observation, home visits, facilitating an art group for members of the ACT team, transporting, and accompanying members to appointments, and attending member's court hearings. In ten records reviewed there were 12 examples of the CC delivering in-person services in the community and at the clinic during a recent month period. Services documented included home visits, assisting in securing housing, meeting with a member and their natural support, medication observation, and teaching daily living skills. Based on a report for the month of August, the CC provided direct services 45% 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 other ACT staff.
H5	Continuity of Staffing	1 – 5 2	Based on data provided, 17 staff left the team since the last review (November 30 – December 1, 2020) resulting in a turnover rate of 71%. Per interview and data reviewed, Nurses were the most difficult to retain with five leaving the team during this time.	• If not done so 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 2	The team operated at 55% of staff capacity during the prior year. The AS position was filled one month prior to the review, however, was vacant for eight months. At least one Nurse position was vacant for seven months during the prior year.	• To ensure diversity of staff, adequate coverage, and continuity of care for 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, ten-hour days on Mondays, Tuesdays, Wednesdays, and Fridays, and attends the program meeting on those days. Staff interviewed reported the Psychiatrist provides services by telehealth (videoconference) to ACT members and is accessible to the team by phone and email, 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. Members interviewed all reported meeting with the team Psychiatrist at least once a month through videoconferencing at the ACT clinic. Per review of 10 records, the Psychiatrist provided direct service to seven members in the month period reviewed.	
H8	Nurse on Team	1 – 5 1	The ACT team had no Nurses on staff at the time of the review.	• Ensure appropriate ACT team coverage of two 100% dedicated, full-time Nurses per 100 members. • Continue efforts to recruit and retain Nurses to ensure consistency of coverage for clinic-based services, as well as community-based services.

H9	Co-Occurring Specialist on Team	1 – 5 4	The ACT team is staffed with two COS. One COS recently joined the team in September 2022, and per resume provided and interview with staff, has some experience providing groups and individual treatment to individuals with a substance use disorder. The second COS, a Licensed Associate Substance Abuse Counselor, has been on the ACT team since 2016. Per *Relias* training records provided, and since the last review, the COS lacks recent training related to treating co-occurring disorders. The COS staff receive weekly clinical supervision by a Licensed Professional Counselor and attend group supervision bi-weekly.	• Provide annual training to COS in co-occurring treatment best practices, including appropriate interventions, i.e., stage wise approach, based on members' stage of change.
H10	Vocational Specialist on Team	1 – 5 3	At the time of the review, the Rehabilitation Specialist position was vacant. The ES joined the team in September 2022. The ES joined the team one week prior of the review and training records showed completion of AHCCCS-*NEO-Employment Rehabilitation* training. According to staff interviewed and the resume provided, the ES has several years of experience providing supported employment services to individuals with a serious mental illness as a Vocational Rehabilitation Specialist.	● Fill the second Vocational Specialist position. ● Ensure vocational staff receive ongoing training, guidance, and supervision related to supports and best practices that aid members to obtain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, employer engagement, and follow-along supports. ● If not done so already, support Vocational Specialist staff to attend quarterly vocational meetings available through the Regional Behavioral Health Authority to keep up to date on resources available.
H11	Program Size	1 – 5 4	At the time of the review, the team was composed of eight staff. There were four vacant positions which included two Nurse positions, the	• Hire and maintain adequate staffing. A fully staffed team allows the team to consistently provide diverse coverage; allows staff to practice their specialties

			Independent Living Specialist, and the Rehabilitation Specialist. *This item does not adjust for the size of the client/member roster.*	which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member. Ideally, 10 or more staff work on an ACT team.
O1	Explicit Admission Criteria	5	Staff interviewed reported members are referred by internal and external clinical teams, inpatient psychiatric teams, and on a rare occasion from the Regional Behavioral Health Authority. The ACT team utilizes the *Mercy Care ACT Admission Criteria* to screen potential members and usually occur by phone or conducted in person when a potential member is referred from the clinic's supportive team. The CC conducts most of the screenings, but the entire ACT team is also trained. The CC and Psychiatrist will staff a potential member with the team, but ultimately the Psychiatrist makes the final determination for new admissions. The ACT team has a clearly defined target population and reports rarely feeling pressured to admit members to the team.	
O2	Intake Rate	1 – 5 5	Per data provided, the team has an appropriate rate of admission with less than six members per month admitted in the past six months. The months with the highest rate of admissions were March and August with two new members each added to the ACT team roster.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team provides psychiatric and medication management services, co-occurring disorder treatment, housing support, and employment support. Only two members on the ACT team reside in staffed locations. One member is engaged in a work adjustment training program outside the team.	• Consider options to include staff on the team that can provide individual counseling to members. Counseling/psychotherapy should be available on ACT teams and provided by ACT staff.

			Members interviewed indicated they have received housing and employment support from staff on the ACT team. Members interviewed reported only receiving services provided by the ACT team and that they would ask the ACT team for help if there were services they were seeking. Counseling/psychotherapy for ACT team members is provided by an agency Licensed Associate Counselor that works with members assigned to the team one day a week. Staff estimated six to eight members meet regularly with the provider. Additionally, staff reported at least one member is engaged in counseling outside of the agency per record review. Members interviewed also indicated that they receive counseling off the ACT team.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour crisis response services to members, rotating on-call duties weekly. There is a back-up to the on-call so when needed, the response to a crisis in the community, is team based. The *West Valley ACT Brochure* is given to members when they first come to the team. It contains the phone numbers and information members would need in case of a crisis. All members interviewed were aware of the ACT on-call line and some had reported using it. The ACT team is available after hours, weekends, and holidays. Records reviewed indicated detailed events of staff providing support to members after hours by phone and staff going into the community in the evening to provide members support. Evidence of staff encouraging members to call the ACT on-call line after hours was documented in charts reviewed.	

O5	Responsibility Hospital Admissions	1 – 5 3	Staff indicated the team is directly involved in member psychiatric hospital admissions. During business hours, staff reported when members call and are in crisis, or experiencing an increase in symptoms, ACT staff will coordinate with the CC. A decision is then made whether to go out to the member's location and meet with the Psychiatrist via telehealth platform, or to have the member come to the clinic to be assessed by the Psychiatrist. After hours when a member is in crisis or experiencing an increase in symptoms, the team assesses the situation by completing a three-way call with the CC to resolve the issue and to ensure safety. If the member contracts for safety, and the team feels the situation is safe, the team will schedule the member with the Psychiatrist as soon as possible. If the member cannot commit to safety and the team is unable to get the member to meet with the Psychiatrist, the team will assist the member in getting to the hospital. Staff or law enforcement will transport the member to the hospital where ACT staff will wait with the member and help them fill out paperwork until they are admitted. Once the member is admitted, a doctor to doctor is completed and ACT staff coordinate with the inpatient team Mondays, Wednesdays, and Fridays to get updates on member progress via email or phone. Initial staffings are completed by phone or teleconference within 72 – 96 hours of admission with the inpatient team. Ongoing	• 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.

			staffings are conducted weekly for members that are inpatient for more than seven days. When members self-admit to a psychiatric hospital, staff reported they have access to a report that alerts the team of an admission and will contact the inpatient team for an update right away. There was evidence in the records reviewed of the Psychiatrist coordinating with the inpatient doctors to discuss a member's progress. According to the data provided and staff interviewed, the team was involved in six of the ten most recent psychiatric hospital admissions. These admissions occurred over a three-month period. One member self-admitted twice, and two others sought medical treatment first and were then admitted for inpatient psychiatric care without the team being notified.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Based on data provided, staff interviews, and record reviews, the ACT team was involved in eight of the ten most recent psychiatric hospital discharges. Staff interviewed indicated when a member is ready for discharge, ACT staff will pick up the member from the hospital, transport to the clinic, a pharmacy, or to the member's home. Appointments with the Psychiatrist and Nurse are scheduled within 72 hours and may occur on the same day of discharge. A five day follow up will take place which ensures members are seen in-person at the clinic or in the community by ACT staff every day for the next five days.	• Ensure the team delivers post psychiatric hospital follow up services and supports as described during interviews.

			Staff is alerted of the discharge and five day follow up during the team meeting. A team staffing is held within four weeks of discharge to discuss member progress or concerns since discharge. In one member record reviewed, there was evidence of staff involved in two hospital discharges including transportation, appointments with the Psychiatrist and Nurse within 48 hours of discharge. However, the five-day follow-up was not completed according to the records.	
O7	Time-unlimited Services	1 – 5 5	Data provided showed the ACT team graduated four members in the last 12 months. Staff interviewed reported the team expects four members to graduate from services in the next year. The team primarily relies on the Psychiatrist to determine member readiness for graduation and stepping down support. However, one record showed staff lacking the ability to support a member's choice in the level of participation with the ACT team and to inform that participation is voluntary.	
S1	Community-based Services	1 – 5 4	Staff interviewed reported 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 60% of the time in the community. Members interviewed provided varied responses related to service frequency for community and office visits.	● Continue efforts to deliver services to members in their communities. Consider evaluating 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 their members in the last 12 months. The ACT team identified three members that were closed.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reported that when the team loses contact with members, an *8-Week Outreach* plan is implemented. Per the outreach document provided and reported by most staff interviewed, each week there is a list of outreach activities that the team is to complete. This includes contacting hospitals, jails, morgues, shelters, probation officers, payees, and travel to common areas where the member would usually be located. In addition, the team attempts to contact the member and natural supports by phone, and by attempting home visits. The attempts are to be documented by date on the *8-Week Outreach* document for each member and tracked on member calendars. Staff reported conducting these different strategies of outreach two to three times a week for eight weeks before moving a member to navigation status. During the program meeting observed, staff reported on efforts to engage members on outreach. Records reviewed showed street outreach efforts by staff at specific locations, attempted phone calls with the member, calling hospitals, and contacting natural supports. However, records lacked evidence of the frequency of two to three contacts a week for eight weeks. In one record reviewed, the member continued to *no show* appointments at the clinic with the Nurse and Psychiatrist. There was no follow up by the team for seven days, and then not again for another 14	● Monitor documented outreach and contacts with members and evaluate the team's approach to building rapport with disengaged 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 that outreach efforts are documented. This may enable the team to proactively assign staff to outreach members in the event of lapses in contact. ● Ensure staff are familiar with the outreach expectations outlined in the *8-week Outreach* protocol.

			days after staff completed a home visit. Another record reviewed had nothing documented for three months until the team was notified the member was picked up on a petition and subsequently went to an inpatient unit.	
S4	Intensity of Services	1 – 5 2	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 about 34 minutes. The highest member record reviewed indicated a rate of intensity of 92.5 minutes a week and the lowest member record reviewed indicated a rate of intensity of zero 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 2	Of the ten records randomly sampled, ACT staff provided an average frequency of 1.88 in-person contacts to members per week. Staff reported limited ability to provide services to members in the community due to the frequency of covering blue dot responsibilities and to attend Psychiatrist appointments with members at the clinic. Members interviewed reported variations of how often they meet with staff during a week period. Several reported only meeting with staff once a week, while one member reported engaging with staff up to four times a week.	● Increase the frequency of contact with members by ACT staff, ideally 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. ● While recognizing the vacant Nurse positions, consider a different schedule how staff are assigned to blue dot and how often staff are assigned to the office versus time in the community.
S6	Work with Support System	1 – 5 3	Data provided and confirmed by the staff showed 47% of members have natural supports. Staff estimated having regular contact with about 64% of members' natural supports once a week by email, phone or in—person. During the program meeting observed, ACT staff reported engagement with 15 members' natural supports. Natural	● Increase contacts with natural supports to an average of 4 per month for each member with a support system. As much as possible, contacts with natural supports should occur during the natural course of delivery of services provided to members, i.e., during home visits.

			support contacts are tracked on members calendars during the program meeting. Based on the ten member records reviewed, there were eight natural support contacts documented for four members within the month reviewed. Members interviewed reported ACT staff having no contact with natural supports. One member reported living with natural supports and stated that however, staff do not engage with their supports while conducting home visits.	• The team may benefit from training on the value of engaging natural supports into member care. The Peer role on ACT teams often provides support to those supports, modeling appropriate language, providing psychoeducation, and encouraging engagement in member care. Some clinics provide groups specifically for natural supports.
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 3	Per interviews and data provided, 32 members were identified with a co-occurring disorder. Staff interviewed reported 20 - 25 of these members are receiving structured individual counseling from a COS. Staff reported seven to ten members receive counseling every week and several members meet with the COS every other week. Staff report even though some members decline services, they continue to offer individual co-occurring disorder treatment at least once a month. Sessions range from 10 - 30 minutes, depending on member preference and stage of change. The model used is Integrated Co-Occurring Disorder Treatment (ICDT) based on the *URICA* stages of change. Four of the ten records reviewed were identified by the team as members with a co-occurring disorder diagnosis. Two additional records were also persons with a co-occurring disorder. However, records reviewed for a month period showed no instances of individual substance use treatment services provided to members with a co-occurring diagnosis. One member was offered	• Work to increase the time spent in individual sessions and increase the number of members engaged so that the average time is 24 minutes or more per week across the group of members with co-occurring diagnoses. • Train staff on the *stage wise approach* to engage members in individualized treatment as appropriate, based on their stage of change. Staff should offer and document individual treatment to members with co-occurring diagnoses. Explore training on strategies to engage members in 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 applicable. • Consider tracking member co-occurring disorder treatment participation duration

			to engage in individual co-occurring disorder treatment during an appointment with the Psychiatrist.	and frequency on member calendars to monitor services provided.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff interviewed reported one co-occurring disorder treatment group is offered to the 32 ACT members with a co-occurring disorder each week which lasts 20 - 30 minutes. Staff reported three to ten unique members attend the group weekly. A review of the attendance sign-in sheets for the month prior to the review showed several members attended at least one ICDT group, however, only three of the members were identified as having a co-occurring disorder by the team. Of the ten records reviewed, there was evidence of staff encouraging members to attend the various groups at the clinic, although the exact group was not specified. The records did not show any of the four members with a co-occurring disorder attending a group in the month reviewed.	• 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. • Consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach.
S9	Co-occurring Disorders Model	1 – 5 4	Most staff interviewed reported a harm reduction approach and provided examples of tactics and interventions used. Staff reported they "meet members where they are at" and the goal is never abstinence unless that is what the member desires. Staff reported being cross trained in ICDT by completing trainings in Relias, team trainings facilitated by the CC, COS, and Clinical Director. The team has incorporated questions based on knowledge of co-occurring disorders and harm reduction into the interview process for potential ACT staff. New hire ACT staff attend the ICDT	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Treatment for Co-Occurring Disorders, 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.

			groups and observe the COS for additional training. ACT staff do not refer members to Alcoholics Anonymous or detox programs unless it is the member's expressed request. Records reviewed indicated members with a co-occurring disorder had treatment plan goals written in their perspective. Some goals were based in traditional language and identified referring the member to outside sources. Only one record reviewed had documentation of ACT staff engaging a member in co-occurring disorder treatment.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has at least one staff with lived psychiatric experience, the PSS. It was reported that the PSS shares their story of recovery when appropriate with members. Staff interviewed indicated the PSS is an invaluable part of the team and that the team appreciates their perspective as a peer. The PSS holds all the responsibilities as other ACT staff.	
Total Score:		**102**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	3
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	2
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	1
9. Substance Abuse Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	4
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	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	3
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	**3.64**	
Highest Possible Score	**5**	