ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 24, 2017

To: Granville Monroe, F-ACT Three Clinical Coordinator
Frank Scarpati, CEO

From: T.J. Eggsware, BSW, MA, LAC
Jeni Serrano, BS
AHCCCS Fidelity Reviewers

Method

On May 2-3, 2017, T.J. Eggsware and Jeni Serrano completed a review of the Community Bridges Inc. (CBI) Assertive Community Treatment (ACT), Forensic ACT Team Three. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

CBI operates five ACT teams, two ACT teams located in Avondale, AZ, and three Forensic Assertive Community Treatment teams (F-ACT) that operate out of downtown Phoenix, AZ at the Human Services Campus. F-ACT Team Three began operations on May 2, 2016, and is the focus of this review. The agency website describes its ACT services and notes there are "mutual expectations between the team and its patients that are met collaboratively," which include "face to face engagements at least 4 times per week, creating and developing support systems, maintaining home visits, all in an effort to help identify and work towards patient goals."

The individuals served through the agency are referred to as *clients* or *patients*, but for consistency in fidelity reports, the term "member" will be used in this report.

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

- Observation of a daily F-ACT team meeting on May 2, 2017;
- Individual interviews with Clinical Coordinator (i.e., Team Leader), Peer Support Specialist (PSS), the team Nurse, and the team's Substance Abuse Specialists (SAS);
- Group interview with eight members;
- Charts were reviewed for ten members using the agency's electronic health records system; and,
- Review of the agency documents and resources, including: agency website*; ACT Operational Manual* and *F-ACT Admission Screening* developed by the Regional Behavioral Health Authority (RBHA); F-ACT individual substance use treatment sessions calendar; resumes and/or training records for the staff identified in the SAS and Vocational Specialist positions (i.e., RS and Employment Specialist).

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 adequately staffed to ensure a small member to staff caseload ratio, and is of sufficient size to consistently provide necessary staffing diversity and coverage to the 75 members served at the time of review.
- The team maintains a low admission rate and experienced few drop-outs over the year prior to review, ensuring consistency and continuity of care for members. Staff reported no instances of members who were closed due to lack of contact.
- The agency website provides general information to community members about ACT services available.
- The F-ACT team has a PSS, in addition to other staff on the team who are individuals with a lived experience of recovery from substance use, mental health conditions, and/or contact with the legal system. Members interviewed reported staff are relatable, and they are inclined to accept staff suggestions due to their shared experiences.

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

- Work with each member and their support network to discuss how the team can support members in the community to avert, or to assist in a hospital admission, if the need should arise.
- Increase the frequency of community-based services to members versus services delivered in the office setting. Work with members to identify activities in their communities that align with their interests, preferences, and recovery goals. Other than co-occurring disorder treatment groups which are likely to occur in the office setting, avoid creating additional office-based groups. Carefully assess the intended purpose, target population, and timelines for groups.
- Seek to build rapport and trust with members to identify and engage their support systems; educate them on how the team can provide support. Review with members the potential benefits of authorizing F-ACT staff to include supports in treatment, when people face challenges, and to celebrate success toward recovery. Ensure staff are trained on confidentiality guidelines in terms of how they can interact and what can be shared with established informal supports.
- Provide ongoing training and clinical guidance to all staff in stage-wise treatment approaches, interventions, and activities for co-occurring treatment. Increase the frequency and diversify the focus of co-occurring treatment groups to accommodate members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). Review and confirm members with an identified co-occurring diagnosis to ensure all staff are aware of their statuses and can offer treatment accordingly.
- Monitor staff documentation to ensure it reflects the specific contact for each member. For certain types of contact (e.g., peer support), the exact phrasing was used from member to member, and from staff to staff.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team serves 75 members with nine staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of about 8:1.	
H2	Team Approach	1 – 5 (4)	Members interviewed reported they have contact with multiple staff on the team. Staff interviewed reported having assigned caseloads for certain paperwork related duties. Based on ten records reviewed, 70% of members met with more than one staff over a two-week period.	• Ensure all members are served by the full team, resulting in 90% or more of members having face-to-face contact with more than one F-ACT staff consistently over two week periods. Ensure all contacts are documented in member records.
H3	Program Meeting	1 – 5 (5)	The program meeting is held five days a week, and all members are discussed at least four days a week. On Wednesdays, members with complex issues are discussed in more detail. During the morning meeting observed, conversation progressed at a brisk pace, but time was allotted for discussion of pressing issues or changes in status, and identifying members for more in-depth discussion during the Wednesday meeting. The team Psychiatrist and Nurse schedules rotate between four ten-hour days and five eight-hour days. They generally attend team meetings four to five days a week, unless not scheduled to work, or if there is an urgent issue. Staff reported the duration of member contacts as they discussed recent services rendered, but it was unclear how this added to the conversation for each member.	• Review the pros and cons of reporting the duration of member contacts during the team meeting. Ensure this is necessary, if it can be tracked through other means (e.g., electronic health record), and if the time saved could allow for more detailed discussion on member status.
H4	Practicing ACT Leader	1 – 5 (4)	The CC estimates his time providing direct member services at around 50% or above. Based on ten member records reviewed, it appears the Clinical Coordinator (CC) provides services to members most often at the office, and at times in the community (e.g. when completing medication observation). Based on review of the CC's	• The CC should provide direct services 50% of the time. Where possible, streamline or eliminate CC administrative tasks not explicitly connected with his role as a F-ACT leader, with a goal of increasing the opportunities to provide direct member services, to model interventions, and

Item #	Item	Rating	Rating Rationale	Recommendations
			productivity report over a month period, the supervisor provides direct services to members roughly 39% of the time.	support the team specialists.
H5	Continuity of Staffing	1 – 5 (3)	Per data provided, five staff left the team during the year timeframe, including two prior CCs. Additionally, two Psychiatrists provided coverage for the team from May to July 2016, prior to the current Psychiatrist officially joining the team in late August 2016. The team experienced over 58% staff turnover during the 12-month period.	• Staff satisfaction surveys and exit interviews may aid administrators in gathering information on reasons why staff leave positions, and help to establish or refine policies that support retention.
H6	Staff Capacity	1 – 5 (4)	The team operated at approximately 83% of staff capacity during the year of operation. Certain positions such as Psychiatrist, Nurse, and SAS were vacant for multiple months, but other positions were quickly filled, mitigating the impact of staff turnover.	• Continue efforts to hire and retain qualified staff. Work with administration to thoroughly vet candidates to ensure they are the best fit for the position and the demands of a F-ACT level of service.
H7	Psychiatrist on Team	1 – 5 (5)	The full-time Psychiatrist assigned to the team has no other administrative responsibilities and rarely sees members from other teams. Staff report the Psychiatrist is an integrated member of the team, is accessible to them, will respond to texts or phone calls promptly, delayed only when she is meeting with a member, and provides community-based services at least one day a week.	
H8	Nurse on Team	1 – 5 (3)	There is one full-time Nurse assigned to the team. She has no other administrative responsibilities, and rarely sees members from other agency teams. Nursing activities occur in the office and community, and include: treatment planning, Nursing intakes, health risk assessments, medication education to members and other staff, injections, filling medication packs, facilitating urinalysis (UA), monitoring vital signs, and coordinating with healthcare providers. Staff reported that the Nurse is accessible, responds to	• Hire a second Nurse to serve the members as the team census increases. This may allow more flexibility in coverage, or increased involvement of Nurses in medication observations, education, and training.

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			texts or phone calls promptly, and is also available during the evening and weekend if needed.	
H9	Substance Abuse Specialist on Team	1 – 5 (4)	One team SAS completed her graduate degree in professional counseling in December 2015, and joined the team in September 2016. In addition to relevant coursework, the SAS received training through the agency and RBHA during her approximate seven months on the team, such as integrated treatment for co-occurring disorders. Based on interview and resume review, this staff's prior experience was primarily with individuals in an urgent care setting, and with children and families, but not specific to co-occurring treatment with adults diagnosed with a SMI. The second staff has experience working in a detoxification setting, and joined the team in May 2016. The staff member's training record showed approximately 25 hours of training on substance use treatment, engagement, and assessment. The staff was identified as a SAS in data provided, but in documentation referred to himself as an AS (i.e., ACT Specialist). One staff interviewed reported the team had just one SAS.	• Provide ongoing clinical supervision to SASs on a stage-wise approach to co-occurring treatment, and aligning staff activities and interventions to each member's stage of treatment. • Ensure members are aware the AS is the second SAS on the team. Consider requesting that staff note their specialty position in documentation (i.e., noting SAS rather than AS).
H10	Vocational Specialist on Team	1 – 5 (3)	The ACT team ES joined the team in June 2016, and the RS joined the team in April 2017. Per CC report, the ES is a certified re-entry employment specialist, which required 24 hours of education; both the RS and ES complete trainings with the RBHA. The ES also received training on Disability Benefits 101 and work incentives, and ES training through the RBHA per training records. It was not clear if the RS has prior direct experience in vocational services related to assisting members to obtain and maintain employment in integrated settings. Per the RS's training record provided, she has received guidance on connecting members	• Ensure Vocational Specialist staff receives ongoing supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings. Training areas of focus include: job development, individualized job searches, and follow-along supports.

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			with meaningful community activities, using the Vocational Assessment Profile, and resources.	
H11	Program Size	1 – 5 (5)	The team is of sufficient size to provide coverage, with ten direct service staff.	
O1	Explicit Admission Criteria	1 – 5 (5)	Members are referred to the F-ACT team by staff at the Arizona Department of Corrections, other provider clinics, and through the RBHA. The CC or other experienced F-ACT staff meet with potential members to discuss the voluntary services, and complete screenings using the *F-ACT Admission Screening*, which is later reviewed with the team. If the member agrees, the team makes the final determination whether the individual will join the team. The CC reports no administrative mandates to accept admissions to the team.	
O2	Intake Rate	1 – 5 (5)	Recruitment efforts are not occurring due to a lengthy list of members scheduled to join the team. At the direction of the RBHA, the team sought to add members at a higher pace when the team began offering services. A maximum of 20 members were admitted for the first two months, and a maximum of ten were admitted on the third month, then no more than six were added in subsequent months. Admissions to the team over the six months prior to review ranged from zero to six members per month, with the peak rate of six that occurred in March 2017.	
O3	Full Responsibility for Treatment Services	1 – 5 (4)	In addition to case management, the team directly provides psychiatric services. Substance abuse group and individual treatment is also provided through the team. However, two members are mandated through the legal system to receive treatment from an external provider, and members in recovery homes/half-way houses are usually required to participate in 12-step	• Continue efforts to build working relationships with correctional system representatives in order to demonstrate that the F-ACT team is capable of providing substance abuse treatment, counseling, etc. so they do not mandate members receive treatment through external providers.

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			programs. The team provides employment or other rehabilitative services, partnering with Vocational Rehabilitation (VR), but F-ACT staff reportedly goes into the community with members to look for employment. Five members attend a group to complete the master application process, (a document to capture work history), but no members receive vocational support services from external providers. Members can receive counseling/psychotherapy through the team, and staff cited an example of the team SAS providing counseling to a member's family. A small number of members are mandated through the legal system to receive specific treatment, such as anger management or dialectical behavior therapy (DBT), from an external provider. The team provides in-home services, and assists members to explore housing options if the need arises, but it appears more than 10% of members are in settings where other social service staff may provide support, including: residential, community living residence, flex-care, group home, and recovery homes/half-way houses.	• Work with members in their communities (e.g., meeting at local library) rather than as an office-based group, if the completion of a master application is necessary in exploring employment. • Work with members to locate safe, affordable, and integrated housing in the community where ACT staff are the primary service provider, with a goal of reducing the number of members who receive in-home support from social service staff who are not part of the ACT team.
O4	Responsibility for Crisis Services	1 – 5 (4)	Staff report the team is the first responder to crisis situations. ACT staff reported that the team is available through the team's on-call phone, with coverage that rotates among staff daily. Documentation reflected services that occurred at various hours of the day and evening. After initially assessing an issue, staff may refer members to the county warm line if they just want to talk with someone. Members interviewed confirmed that staff are available 24 hours a day, seven days a week, and one cited an example of receiving support in the early morning.	• Evaluate how the F-ACT team can support members in their communities to minimize the need to utilize staff or other CBI facilities that are not part of this F-ACT team.

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			Staff reported that they occasionally receive calls relayed through the CBI Access to Care line. Staff reported they utilize other CBI facilities if members need stabilization services, including 23 hour observation, detoxification, and support for members who may be a danger to themselves or others. However, services at the facilities are not psychiatric inpatient admissions, per staff report.	
O5	Responsibility for Hospital Admissions	1 – 5 (2)	Staff estimated the team is involved 70- 80% of the time, reporting the team is involved as soon as they are informed, but confirmed certain members self-admit without contacting the team. The team was not involved in seven of the ten most recent psychiatric admissions based on discussion of those admissions with the CC.	• Work with each member and their support network to discuss how the team can support members in the community to avert, or to assist in a hospital admission. Develop plans with members in advance, especially if they have a history of admitting without informing the team.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (4)	Staff reported the team is involved in nearly all hospital discharges. Based on review with the CC, the team was involved in nine of the ten most recent member psychiatric inpatient discharges. Per report, when members are inpatient, the team completes a Continuation Of Care (COC) report to keep stakeholders apprised of a member's status. Staff have contact with the member, and the inpatient Social Worker. The Nurse and Psychiatrist make an effort to attend staffings, and the Psychiatrist conducts doctor-to-doctor consultations with the inpatient provider. Staff picks up the member at discharge, ensures an appointment with the team Psychiatrist occurs, and assists members to obtain medications.	• Work with each member and their support network to discuss how the team can support members discharging from an inpatient setting. Educate inpatient staff on the F-ACT team's role in discharge planning, availability to assist with discharges, etc.
O7	Time-unlimited Services	1 – 5 (5)	Per staff report, no members graduated due to significant improvement over the 12 months prior to review. It was projected that two members, slightly fewer than 3%, were likely to graduate in	

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			the next twelve months.	
S1	Community-based Services	1 – 5 (3)	Staff reported they spend 70-80% or more of their time in the community. Two members reported the Nurse has visited their home. A subgroup of members interviewed reported staff visit with them at their home weekly, or multiple times per week. Based on ten member records reviewed, members who received other supports at the campus where the F-ACT team is located tended to have more office-based contacts. The rate of community-based services documented in records reviewed showed that a median of 46% of services occurred in the community. The rate includes three members whom received all services in the community, one of who received an average of more than four contacts weekly during a month. In addition to a co-occurring disorder treatment group, F-ACT staff also facilitates office-based groups (e.g., employment).	• Ensure all services performed by ACT staff are documented. • The F-ACT team should increase community-based services to members, with the goal of 80% of contacts being made in the community versus the office setting. Prioritize individualized contacts with members in their communities, where staff can support them to connect with their natural supports, or identify resources. Other than co-occurring treatment groups, which are likely to occur in the office, activities should occur primarily in the community.
S2	No Drop-out Policy	1 – 5 (5)	Based on data provided for the year prior to review, no members closed due to the team determining they could not be served, refusing services, or could not be located. The team identified three members who left the geographic area without informing the team of their plans, and the team could not proactively assists with those transitions. However, for one of those members, the team coordinated with family, arranged for medications for the period before the member could begin services in the new area, and facilitated a transfer to another RBHA. A second member was on the caseload for a brief amount of time following release from incarceration. The team assisted the member with medications, and coordinated with the out-of-state provider. One member was picked up by family after release	

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			from incarceration, and moved to another area of Arizona without informing or involving the team.	
S3	Assertive Engagement Mechanisms	1 – 5 (4)	Agency documents indicate if a member is on outreach/missing. The team completes four outreach attempts for eight weeks, and if not found, the member is closed unless clinically indicated by the Psychiatrist to complete additional outreach. Staff reported they are required to complete a minimum of two physical outreaches weekly, but they strive to do four. Efforts reportedly include contacting payees, legal system representatives, hospitals, as well as looking for members on the campus where the team is based, attempting connect with the member at their last known location, and other community outreach. Members interviewed specifically cited the importance of F-ACT staff being available at their time of release from incarceration, waiting for them at the release gate. During the morning meeting observed, staff discussed outreach for members who were not in contact with the team. Staff reported which staff performed outreach, identified which staff would outreach that day, and planned for a subsequent outreach, but did not consistently identify the method or location of outreach. As result, it was not clear if staff used an established outreach plan to coordinate efforts to minimize overlap. For one member, over the course of ten days, different staff documented six outreach efforts at the campus where the team is housed, with limited evidence of other outreach. One note indicated jails and hospitals were contacted, but did not specify which hospitals.	• Diversify the outreach efforts, to include other efforts in addition to street and shelter outreach. Ensure all efforts are documented so that staff is aware of outreach that has occurred, and aligns subsequent outreach with the member's individualized outreach plan. Following a formal engagement strategy may aid the team as they track outreach efforts.
S4	Intensity of Services	1 – 5	The median intensity of service per member was	• Increase the intensity of services to

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		(4)	just over 94 minutes a week based on review of ten member records. Two members received over 210 minutes of average service time per week during a month period, but four members received 50 minutes or less on average per week.	members, optimally averaging two hours a week or more of face-to-face contact for each member. Work with staff to identify and resolve barriers to increasing the average intensity of services to members.
S5	Frequency of Contact	1 – 5 (3)	Ten member records were reviewed to determine the amount of times per week each member is receiving face-to-face contact. The median face-to-face contact was 2.75 per week over a month timeframe. The average contacts per member per week ranged from .5 to 7.75. Members who receive medication observation services received a higher frequency of contacts with multiple staff.	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support specific member goals rather than primarily medication observation. Ensure all services are documented.
S6	Work with Support System	1 – 5 (3)	Two staff interviewed reported that approximately 57%-75% of all F-ACT members have informal supports, and another staff estimated that about 50% of her primary caseload have informal supports. All three staff reported that the team averages at least weekly contact a month with those supports. During the morning meeting observed, recent contact with informal supports, or plans to contact informal supports was discussed for under 20% of members. In ten member records reviewed, the average contact was just over once per month, but there was no contact with informal contacts noted for most members. One staff reported barriers to engaging informal supports if the member has not authorized them to be involved in their treatment, but that staff revisits the topic to employ members to allow informal support involvement.	• On a recurring basis, revisit with members to identify their informal supports. For example, the F-ACT team works with members involved with consumer operated programs, so there may be opportunities to identify and build on informal supports they develop by interacting with other individuals at those locations. • Educate informal supports about ways to support member recovery. Review options to develop a family psychoeducation group, and/or assist families to connect with other informal supports so they can share their experiences, receive mutual support, etc. Try to engage informal supports in treatment, not just narrowly focusing on the treatment planning process.
S7	Individualized Substance Abuse Treatment	1 – 5 (4)	There was evidence of individualized substance abuse treatment in documentation reviewed, but it was usually provided by one of the two SASs. The second SAS (i.e., identified as AS in	• Review which members have an identified co-occurring disorder so that the team can appropriately plan and carry out treatment with those members.

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			documentation) seemed to focus on early engagement efforts to raise awareness of substance use issues as an element of general case management during home visits or other activities. Documentation from that staff captured activities such as assisting with housing applications, completing home visits, and peer support. Staff reported all members with a co-occurring disorder receive at least weekly 30 minute individual sessions. However, there was incongruence in staff report of how many members on the team have a co-occurring disorder. One staff reported 55 members, another reported 37, and a calendar of individual substance abuse counseling sessions for April 2017 was provided that showed 46 members. Based on the calendar, it appeared most of those members (27) were assigned to the first SAS, and the remaining members (19) were assigned to the second SAS (i.e., AS in documentation). Based on records reviewed, not all members received weekly individualized substance abuse treatment as reported. For example, one member had one contact with an SAS over a month period, but it was not clear if individualized treatment occurred, and another member had one individual treatment with an SAS during a month timeframe.	• Provide ongoing training to SASs and make available ongoing supervision to support their efforts to provide individual substance use treatment. Engagement efforts should be tied to a proven, co-occurring treatment approach, with staff activities documented that aligns to each member's stage of treatment. Also see recommendations for S9, Co-occurring Disorders (Dual Disorders) Model. • Review the calendar used to monitor and track individual substance use treatment activities for accuracy. Explore options to monitor individualized treatment without creating additional paperwork for direct care staff.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	Per report, the SAS on the team facilitates one co-occurring treatment group weekly which draws from an integrated dual diagnosis treatment (IDDT) model, primarily focused on members in the precontemplation or contemplation stage of change. During the month prior to review, one staff reported five members with a co-occurring disorder attended at least one group. Another	• Review which members have an identified co-occurring disorder so that the team can appropriately plan and carry out treatment with those members. • Inform members, their supports, and system partners of available treatment through the team. Increase the frequency, and/or number, of co-occurring treatment

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			staff reported 18 members attended at least once, but when asked what the average attendance for the group was, she reported that some members had a recurrence of use, and only three members attended one of the groups during the month. Of ten member records reviewed (seven of whom had a noted co-occurring disorder), there was no evidence any attended a group during the month timeframe reviewed. There was limited evidence members were informed of, or engaged to attend, the group. Due to discrepancy in the number of members identified with a co-occurring disorder, and discrepancy in the number of members who reportedly attended at least one co-occurring treatment group, it is difficult to ascertain member participation. It appears 11-39% of members may have participated in group treatment; possibly, as few as 9% participated.	groups offered through the team. Consider aligning the focus of each co-occurring treatment group to accommodate members in different stages (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). • See recommendations for S9, Co-occurring Disorders (Dual Disorders) Model.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (3)	Staff interviewed seemed to be familiar with a stage-wise approach in relation to a member's stage of change, though in documentation and the morning meeting staff relied on stage of change language to describe member statuses. Based on training records, it appears F-ACT staff other than the SAS are also trained in IDDT and American Society of Addiction Medicine (ASAM). Staff interviewed cited examples of a harm reduction approach. Also, some records documented discussions with members in earlier stages of recovery to build awareness of the problem, discussed strategies to reduce use of substances, discussed triggers, and encouraged members to envision a future without substance use. However, one record noted a person in the action stage of precontemplation, and it was not clear if staff had a consistent approach to identify the member's	• Provide ongoing guidance to staff in a stage-wise approach to treatment, interventions that align with a member's stage of treatment, and how to reflect that treatment language when documenting the service. This may better equip other ACT staff to engage members in individual and group SA treatment through the team. • During clinical supervision, review with staff whether research supports AA, and how staff can support members who elect that form of support.

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			stage of change. In another record it was documented that a member was in the contemplation stage, but after a recurrence of use, it was later noted the member was in the action stage of change. Staff reported they do not refer members to Alcoholics Anonymous (AA) or similar groups, but do encourage self-help groups. In records reviewed there were references to maintaining sobriety, involvement in 12-step programs, and shared staff experiences of being in placements to maintain sobriety. A subsection of members (about 16%) are in residences that may require involvement in 12-step meetings. Detoxification may be used, if medically indicated based on substance used. However, if a member resides in a half-way house/recovery home and has a positive UA, the residence may mandate the member to a CBI facility to be medically cleared. It was not clear if individual or group substance abuse treatment was consistently offered or provided to those members with an identified co-occurring diagnosis.	
S10	Role of Consumers on Treatment Team	1 – 5 (5)	The F-ACT team has a full-time PSS, in addition to other staff on the team who are individuals with a lived experience of recovery from substance use, mental health conditions, and contact with the legal system. Members interviewed reported staff can relate to them, want them to progress, and that they are more willing to take staff suggestions due to the shared experiences. Examples of staff sharing their stories were found in member files.	
Total Score:		**3.93**		

ACT FIDELITY SCALE SCORE SHEET

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

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	3
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	3
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	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.93**	
Highest Possible Score	**5**	