ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 13, 2017

To: Laura Larson-Huffaker, Executive Director

From: Georgia Harris, MAEd
Karen Voyer-Caravona, MA, LMSW
AHCCCS Fidelity Reviewers

Method

On December 6 – 7, 2016, Georgia Harris and Karen Voyer-Caravona completed a review of the LaFrontera-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 Maricopa County.

LaFrontera-EMPACT provides behavioral health services to children, adults, and families. Outpatient and inpatient services are available and include: counseling, psychiatric services, substance abuse treatment, trauma healing, crisis intervention, supportive services, and services for adults with a serious mental illness. LaFrontera-EMPACT currently has two ACT teams at the Comunidad location: The Comunidad and Capitol teams. At the time of the review, the Comunidad ACT team had been under the management of LaFrontera-EMPACT for 14 months, after the previous provider organization ceased operation. As a result of the transition some information provided to the reviewers was incomplete; the agency cooperated with the reviewers in clarifying missing data where they were able.

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

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

- Observation of a daily ACT program meeting;
- Individual interviews with team leader/Clinical Coordinator (CC), the Rehabilitation Specialist (RS), and the Peer Support Specialist (PSS);
- Group interview with both Substance Abuse Specialists (SAS);
- Group interview with seven members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Examination of agency documents including: the Regional Behavioral Health Authority (RHBA) developed ACT Admission Screening Tool, the CC's encounter report for the period under review, the ACT team program meeting notes, SAS individual substance abuse treatment tracking logs, and resumes for the SASs, the RS, and the ES.

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 ACT team has two full time Nurses, providing members with a spectrum of nursing services, including: injections, medication observation, medication education, and coordination of care with primary care and other physical health providers, both in the clinic and in the community. The Nurses serve only the ACT team and have no responsibilities such as supervision of students or other staff to distract them from member needs.
- The ACT team has two highly qualified and experienced Substance Abuse Specialists (SAS) who enable the team to be fully responsible for all co-occurring treatment. One SAS offers two regular clinic based co-occurring groups, and both SASs see a total of about 60 members at least once each month in structured, formal individual substance abuse counseling. Additionally, the team benefits from a Peer Support Specialist (PSS) who helps the members to engage in community substance abuse groups.
- The ACT team has experienced vocational staff; they have a Rehabilitation Specialist (RS) and an Employment Specialist (ES) who are fully responsible for providing members with assistance with vocational rehabilitation, including assistance with employment and educational goals. Members interviewed know the staff who are responsible for this role, and some described their own engagement efforts/accomplishments in this area.

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

- The ACT team should support retention of current staff so that staff turnover rises to no higher than 20% over a 24 month period. Retention of trained and experienced staff will maximize the benefits of the agency's and the RBHA's training efforts and build on the team's cross-training efforts in co-occurring treatment and other specialty areas. Continuity of staff will likewise facilitate trust and rapport with members, which is necessary for effective therapeutic relationships that support the attainment of recovery goals.
- The ACT team should be directly involved with 100% of member psychiatric hospital admissions. Given the high number of self and family initiated admissions, the ACT team should educate members and their informal supports on the benefits of directly involving staff in the decision to seek a psychiatric hospital admission. ACT staff should assist members in avoiding crisis through interventions and guidance that promote greater stability in the community using effective problem solving and identification of resources and supports. The ACT team should increase contact with members' informal support system to four or more each month; informal supports can serve as partners with the team in assisting members in attaining recovery goals.
- The ACT team should increase participation in co-occurring treatment groups so that at least 50% of members identified with a co-occurring disorder attend at least one group per month. Along with efforts by all specialists to encourage substance abuse group engagement, offer various co-occurring groups to accommodate members in different stages of treatment (i.e., engagement,

persuasion, late persuasion, active treatment, relapse prevention).

- The ACT team should avoid too much reliance on group activities in the clinic to meet encounter targets. ACT emphasizes individualized, purposeful interventions that are integrated in community settings, where member challenges are most likely to occur. Progress notes in the clinical record should reflect the intervention provided and the member's status, and should be consistent with goals and objectives in the member's ISP.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review the ACT team consisted of 12 staff serving 99 members. Excluding the ACT Psychiatrist, the member to staff ratio was 9:1.	
H2	Team Approach	1 – 5 4	Staff reported that members are seen according to six geographical regions in the county (East, West, Central, North Central, North and South) as well as jail and outreach. Staff are also expected to ensure that everyone on the team roster is seen. Staff interviewed said that caseloads are assigned for the purpose of completion of paperwork such as service plans and assessments. Per a review of ten randomly selected member records, 80% of members saw more than one ACT staff in a two week period.	• Increase the percentage of members seeing more than one staff member in a two week period to 90% or more. Maintaining full staffing may result in improvement in this area. • The CC should periodically review member records to ensure encounters with members are properly recorded. The ACT team and the agency should collaborate to find solutions to any identified barriers to getting documentation of face-to-face staff/member contacts entered into records on time.
H3	Program Meeting	1 – 5 5	The ACT team meets four days a week (Monday, Tuesday, Wednesday, and Friday) for a full program meeting in which all members are discussed. Unless called away to address member needs or on a flex-day, all staff attend the program meeting. On Thursday, the team meets to discuss those members on outreach, those who need to be seen, and those who have gone missing.	
H4	Practicing ACT Leader	1 – 5 4	Per the Clinical Coordinator's (CC) encounter report that was provided to the reviewers, the Clinical Coordinator spent 41% of his actual time providing	• The CC should provide direct member service contacts 50% of the time. • Avoid too much reliance on groups to meet

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			direct member services. The CC achieved 39% of those face-to-face contacts in scheduled groups.	fidelity in this item, and instead prioritize individualized services.
H5	Continuity of Staffing	1 – 5 3	Based on data provided by the agency to the reviewers, the ACT team had a turnover rate of 41.6% in the 24 months proceeding the review period. The clinic's transition from one managing provider to another may have contributed to some staff turnover.	• The agency should strive to retain current staff and reduce staff turnover to no more than 20% in 24 months. • The agency should consider identifying factors that may contribute to both staff retention and turnover, possibly through the use of surveys, focus groups, and exit interviews.
H6	Staff Capacity	1 – 5 5	For the 12 months preceding the review, the ACT team operated at 97% of capacity. The agency filled vacancies quickly. Two staff members were hired from within the clinic. One new specialist reported being actively recruited for the team based on experience with the clinic and in the specialty role.	
H7	Psychiatrist on Team	1 – 5 5	The ACT Psychiatrist has been with the team for several years and dedicates 100% of his time to the ACT members. The Psychiatrist works a four day/ten-hour per day schedule. The Psychiatrist attends four daily program meetings; he does not attend the Thursday outreach meeting, which is scheduled on his day off. Both staff and members spoke highly of the Psychiatrist. Staff described him as playing a strong educator role during morning meetings, and stated that he conducts home visits throughout the week to see members who miss appointments or cannot and/or will not come to the clinic. Staff reported that the Psychiatrist is accessible by phone, email, and text message, as well as available to meet with them personally in the office.	
H8	Nurse on Team	1 – 5 5	The ACT team has two full-time Nurses that dedicate 100% of their time to serving ACT members. Neither nurse has responsibilities outside the team. Both nurses oversee medication, conduct home visits for	

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			outreach and medication administration and observations, provide medication education, and coordinate with primary care providers and Integrated Health Homes (IHH). The Nurses were described by staff as accessible by phone, email, and text message, and they conduct home visits to provide injections and follow up with members who miss appointments. Both work four, ten-hour days, with one taking Monday and the other taking Friday off. Both attend all the program meetings, except for their day off.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has two Substance Abuse Specialists (SASs) with significant training and experience in substance abuse treatment. SAS1 joined the team in August 2016, after having been contracted through another agency for several years at the clinic to provide individual and group substance abuse treatment to supportive team members. He is currently pursuing a Masters in Addiction Counseling. SAS2, who is a Licensed Associate Substance Abuse Counselor (LASAC) and has a Masters in Addictions Counseling, joined the ACT team in September 2016 after serving in several positions since 2011, including Clinical Supervisor and Interim Clinical Director.	
H10	Vocational Specialist on Team	1 – 5 4	The ACT team has a Rehabilitation Specialist and an Employment Specialist who have been in their respective positions since 2009, previous to the transition to the current agency. Per interview, the ES goes into the community to help members look for jobs and fill out applications, while the RS coordinates with VR and makes referrals to peer run programs for members seeking meaningful community activities. The RS worked in various direct service capacities in behavioral health since 2000. The ES worked in behavioral health since 1999. It did not appear that ongoing training and education related to helping	• Ensure that the RS and ES receive ongoing training and appropriate supervision in assisting members in finding and retaining employment in integrated settings.

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			people find meaningful employment in the community was provided. Additionally, no evidence of job-finding activities was found by the reviewers in the record review or noted in the team meeting.	
H11	Program Size	1 – 5 5	The ACT team has 11 staff and is of sufficient size and diversity of specialization to serve the needs of 99 members. The ACT team consists of: Psychiatrist (1), Clinical Coordinator (1), Nurses (2), Substance Abuse Specialists (2), Rehabilitation Specialist (1), Employment Specialist (1), Peer Support Specialist (1), Housing Specialist (1), and ACT Specialist (1).	
O1	Explicit Admission Criteria	1 – 5 4	Staff interviewed said that the ACT team uses the RHBA's ACT eligibility screening tool for assessing appropriateness of admissions to the team. The CC described a typical member admitted to the ACT team has having needs that exceed those that can be provided on a supportive team, someone who is a high service utilizer, who wants and needs a lot of supports to live independently, and may need prompting to take medications. The CC reported that occasionally the team has had to accept referrals to the team when guardians believe that the person needs the extra help and monitoring or when the person has been conditionally released from prison. The CC does most screenings but they may also be done by the SAS1 or the ES. Admissions are voluntary except for those on conditional release or compelled by guardians. Referrals usually come internally or through the RBHA.	• The ACT team, along with approval by the prospective member, should make the final determination regarding who is admitted to the team and should not experience administrative pressure.
O2	Intake Rate	1 – 5 5	In the last six months, the ACT team has admitted seven members to the team. The admissions per month were as follows: June (1), July (2), August (1), September (0), October (2), and November (1).	
O3	Full Responsibility	1 – 5	Along with case management, the ACT team is fully	• As the designated housing provider for ACT

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	for Treatment Services	4	responsible for four out of five specialty services. The ACT team provides all psychiatric services. The two SASs provide all substance abuse treatment, including group and individual treatment. One member self-referred to a methadone clinic. The SAS2 provides individual counseling/psychotherapy. The ES and RS provide all vocational services, including resume development, job search, and follow along support. The RS coordinates with the Rehabilitation Services/Vocational Rehabilitation Administration (VR) for services and needs not funded through the ACT team, such as vocational training and education. Several members interviewed discussed work goals, and one is preparing to graduate from an automotive training program. The ACT team does not refer services to outside providers. While staff are aware that they are considered the primary provider of housing services, including helping members find and retain housing, 13 members reside in housing situations with some level of case management or other support. Of those 13, three live in group homes, including one in Flexcare; four live in halfway houses; one lives in transitional living placement with staff monitoring; two live in Ethyl's House receiving meals and transportation assistance; two reside in substance abuse treatment facilities; and one lives in a skilled nursing facility.	members, the ACT team should assume full responsibility for all housing services, including helping members find housing in integrated community settings and provide support services necessary to retain housing.
O4	Responsibility for Crisis Services	1 – 5 5	Staff interviewed described the ACT team as the first responders in providing 24-hour emergency crisis services. Staff said that they do not use the crisis mobile team, and have an on-call phone that staff rotates daily. Members in crisis can call the on-call directly or call the CC, who is the back-up. Specialists also provided members with a card listing all of staff phone numbers. With the goal of avoiding	

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			unnecessary psychiatric hospitalizations, staff will go on site in response to crisis. In the rare instance that the mobile team or the crisis line is called first, they will call the ACT team so that ACT staff can respond on site. Staff interviewed reported that they do not receive many crisis calls from members and attribute this to regular face-to-face contact.	
O5	Responsibility for Hospital Admissions	1 – 5 1	The reviewers discussed with the CC the last ten psychiatric hospitalizations. The ACT team was not involved in any of the last ten psychiatric hospitalizations. Staff interviewed reported that the number of members who are hospitalized is few, but those who are hospitalized usually admit themselves frequently, doing so in order to solve or avoid other extenuating circumstances (e.g., homelessness). Staff said members often make the choice not to involve the team. Staff at psychiatric hospitals usually make contact with the ACT team within a day or two after admission, but staff at a few hospitals do not. Staff also said that some families, in dealing with emergency, focus first on reacting to emergencies or concerning behaviors rather than contacting the ACT team.	• The ACT team should be directly involved in 100% of all decisions to seek psychiatric hospitalization for members. • The ACT team should educate members and their informal supports on the benefits of involving the team when seeking a psychiatric hospitalization. • The team should identify factors that lead some members to use psychiatric hospitalization to meet needs rather than seeking the assistance of ACT specialists. The ACT team should build partnerships with member and their informal supports that focus on finding recovery oriented, strengths-based solutions to challenges rather than relying on inpatient facilities.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per a review of the last ten hospital discharges, the ACT team was involved in 100%. Discharge planning begins at the time of admission or as soon as ACT staff learn the member has been admitted. Staff begin talking with the hospital social workers about needs post discharge, including housing, wrap around services, and the member's support system. The ACT Psychiatrist has a doctor-to-doctor discussion with the inpatient Psychiatrist regarding medication and aftercare. Staff see members 72 hours after admission and every three days thereafter. Unless arranged otherwise, staff pick up the member from	

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			the hospital, take the member to the pharmacy for medication and shopping for food and any other needed supplies or groceries, and returns the member to his or her residence. The member is seen by the ACT Psychiatrist within 72 hours, and staff do four home visits with the member for the next week.	
O7	Time-unlimited Services	1 – 5 5	Per interview, graduation or "step-down" from the ACT team is viewed as a long-term goal. Members are ready to graduate from ACT when they no longer need ACT's specialized services or support to live in the community on their own, and know how to get their needs met. For example, staff would assess readiness for graduation after seeing for a year or more that the individual is able to maintain housing, hold a job, maintain sobriety, and can take medications without assistance. The member's contact with the team would be reduced for about two months, followed by a discussion with the member about whether or not he or she feels ready. If the member feels ready, he or she would be stepped down to a supportive level of care, or the member could elect to remain on the ACT team. The ACT team did not graduate any members in the last year, although eight members transferred to other ACT teams that were closer to their residences. The CC estimated that over the next 12 months the team will graduate five (slightly above 5%) members.	• ACT services should be provided to members on a time-unlimited basis, with fewer than 5% expected to graduate annually.
S1	Community-based Services	1 – 5 4	Most members interviewed reported that they see staff at their home at least 50% of the time; some reported a higher amount. Per the record review, 63% of direct service contacts with members occur in the community. In addition to co-occurring disorders groups, the ACT team offers various other groups both in the community and in the clinic. One rehabilitation group delivered in the clinic is offered for three hours (10 a.m. – 1 p.m.) daily, Monday –	• Increase delivery of community-based member services to 80%. Focus on the timely documentation to accurately reflect member engagements. • Avoid encouraging members to come to the clinic; staff should focus on providing community-based services where staff can more effectively assess, monitor, and assist

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			Friday.	in problem solving and skill building. • Though group activities my be effective and provide results for some members, the ACT team should avoid a heavy reliance or implementation of site-based groups.
S2	No Drop-out Policy	1 – 5 5	The ACT team retained 98% of its membership over the last 12 months. Two people were closed out from ACT services. Another member left the geographical area to live with family, declining a referral; however, they eventually returned to the team. Staff interviewed attributed the high retention rate to constant outreach. Eight members transferred off the team: six to ACT teams closer to their homes, and two graduated to a supportive level of care.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Although staff interviewed said that they did not have a written assertive engagement strategy, most reported using an eight-week outreach protocol with specific tasks for each week. Some staff did not appear to be readily familiar with the protocol, however. Outreach activities included phone calls and home visits, searches in the community to favored or usual locations, follow up with informal supports, and contact with probation officers, payees, guardians, peer runs organizations, and the Psychiatric Security Review Board (PSRB). Three to four outreaches occur each week and a Notice of Action Letter is sent out after about six weeks, although staff said that one has not had to be sent in the last year. Staff said that members almost always turn up and that contact is often made when staff see the member walking down a sidewalk or waiting at a bus shelter. Staff said that they never close members, and that the agency recently instituted an Outreach Team to continue outreaching members if	• Ensure that all staff are familiar with the eight week outreach protocol. Developing a written outreach protocol outlining assertive engagement tasks for each of the eight weeks may strengthen staff knowledge of the protocol.

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			they exceed eight weeks of no contact.	
S4	Intensity of Services	1 – 5 4	Per the record review, members received an average weekly contact of 118.25 minutes of contact with ACT staff. The reviewers found contacts reflecting individual substance abuse treatment, assistance with resolving housing issues, jail visits, ACT admission assessments, and peer support. Service contacts also included substance abuse groups, as well as other groups such as Healthy Eating Group and Independent Living Skills group.	• Increase weekly intensive services to an average of two hours. Intensity may vary based on the member's stage of recovery, but an average of two hours across the team should be the goal. • Avoid too much reliance on groups to achieve service contacts. Ensure there is a balance of individualized in vivo services that promote skill building, the development of natural supports, self-advocacy, and connection with community services and resources.
S5	Frequency of Contact	1 – 5 4	Per the record review, average weekly contact that ACT members have with staff was 3.63. The records reflected a range of a low of .05 weekly contacts to a high of 9.5 weekly contacts. Similarly to item S4, Intensity of Services, ACT staff achieve this rate partly through contact that occurred in groups not required or recommended by the evidenced based practice protocol.	• Increase frequency of contact to an average of four contacts per week for each member. Contacts should be purposeful, person-centered, and recovery oriented. See also recommendation for S4, Intensity of Services.
S6	Work with Support System	1 – 5 3	Staff interviewed reported that 65% of members have an informal support system, and that through outreach, staff have contact with all of them at least one time monthly. Staff interviewed said they obtain signed release of information forms and that members are selective about with whom they will allow contact. Evidence of this was found in the record review. The ACT team holds a monthly Friends and Family Night that is attended by approximately ten members and two or three informal supports. Per the record review, the average monthly staff contact with informal supports was 1.20 per member. Six records showed no staff contacts with informal supports, two records showed	• The ACT team should have four or more contacts per month with informal supports, for each member with a support system. Staff should discuss with members the benefits of allowing contact with their informal supports. • Continue to obtain current Release of Information/ Authorization to Use and Disclose (ROI/AUD) forms and provide regular outreach to informal supports to cultivate their role as allies in recovery; to provide useful psychoeducation about symptoms and behaviors; and to obtain their feedback on members'

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			one contact, one record showed two contacts, and one record showed eight contacts.	functioning/needs/progress.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Both the SAS1 and the SAS2 provide individual substance abuse treatment, and their primary responsibilities on the team are to cover the co-occurring caseload through constant outreach and engagement. Evidence found in the record review supported this with numerous examples of individual substance abuse treatment sessions and outreach efforts. Both the SASs provided the reviewers with logs of member individual substance abuse sessions for the month of October. About 60 – 64 of the roster of 68 COD diagnosed members receive individual substance abuse treatment at least one time monthly, in sessions ranging from 30 to 60 minutes. The SAS1 and SAS2 split the caseload of COD diagnosed members approximately in half. Across the entire COD caseload, members received an average of less than 24 minutes of individual substance abuse treatment per week.	• Continue current efforts to engage COD diagnosed members in individualized substance abuse treatment to increase the average to at least 24 minutes per week.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	Per interview, ACT staff view participation in co-occurring groups as strongly correlated with positive outcomes. Evidence in the record review showed that ACT specialists routinely encourage members with a COD to attend co-occurring groups. The SAS1 provides two co-occurring groups each week at the clinic. The groups are attended by approximately 11 members per group. About 15.5 (23% of the 68 members diagnosed with a COD) members attend at least one co-occurring group per month. The SAS1 occasionally holds co-occurring groups at the ACT house. Those groups are unscheduled and usually occur organically in the outside common area of the house. Those who attend live at the ACT house, do not attend the clinic based groups, and are actively using illicit substances or alcohol. The SAS2 has not	• Continue efforts to increase co-occurring group participation to 50% of members with a co-occurring disorder. • Consider offering daily COD groups; groups that align with early, mid, and later stages of change; and COD groups that are gender specific.

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			yet started facilitating a co-occurring group but expects to in the future. The SAS1 reported that the agency provides him with the RBHA's co-occurring curriculum, which he supplements with approved materials that he has acquired through his career as a clinician, including materials from Hazelden, Rational Emotive Behavioral Therapy strategies, and the SAMHSA co-occurring curriculum. Groups last two hours each, with the first hour devoted to process and check-in with each member, followed by a short break, and then the second hour devoted to psychoeducation. The SAS1 stated that he tries to use interventions that align with each member's stage of or readiness for change.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The ACT team appears to primarily follow the co-occurring model. The SASs described using a stage-wise treatment approach and were able to easily provide multiple examples of applying interventions that align with members at each stage of or readiness for change. As an example provided in the interview, members in pre-contemplative stage have no interest in discussing their substance use or treatment and should instead be engaged at the level of basic needs and immediate goals of importance to them. The SASs make considerable use of motivational interviewing, as well as cognitive behavioral techniques such a rational emotive behavioral therapy, processing ambivalence, and harm reduction techniques. Staff interviewed appeared trained to use non-confrontational approaches and are interested in providing members with activities in the community as an alternative to use and embrace harm reduction as the most realistic approaches that celebrate reduced use, less lethal use, or budgeting for use for some members. The PSS uses her lived	• The agency and the RBHA should continue efforts to train and support all ACT specialists in the co-occurring model, including a stage-wise approach. Retaining existing trained staff and supporting cross-training from the two qualified SASs may expedite the ACT team becoming fully based in the co-occurring model. • Rather than refer members to 12-step groups, the ACT team should encourage community based 12-step groups as a supplement to co-occurring group treatment. Focus the majority of efforts on keeping members in the evidence based IDDT groups.

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			experience to support members who would like community-based support for their recovery and transports members once a week to various 12-step meetings outside the clinic. The team will refer members for detox if they request it and/or appear to be experiencing symptoms of physical withdrawal.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has a Peer Support Specialist (PSS) who is a full member of the team with the same responsibilities as the other specialists. The PSS shares her lived experience to support the recovery of members, and as mentioned in the previous item, transports and accompanies COD diagnosed members to 12-step meetings in the community. Staff interviewed noted that the PSS has training in substance abuse treatment. Members interviewed know that the PSS is also in recovery, and also identified another staff member as a person with lived experience who discloses when appropriate.	
Total Score:		**4.25**		

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	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	4
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	4
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	1

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	4
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.25**	
Highest Possible Score	**5**	