ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 8, 2023

To: Lora Sayles, LAC, Clinical Coordinator
Dr. Beth Darling, DO
Eugene Cavallo, Vice President of Behavioral Health

From: Nicole Eastin, BS
Kerry Bastian, RN
AHCCCS Fidelity Reviewers

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 January 10 – 11, 2023, Fidelity Reviewers completed a review of the Valleywise Mesa Riverview 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.

Valleywise, formerly known as Maricopa Integrated Health Systems, provides a wide range of inpatient and outpatient integrated health services in the Central Region of Arizona. This review will focus on this stand-alone ACT team.

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 and telephone to interview staff and members.

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

- Remote observation of an ACT team program meeting January 10, 2023.
- Individual video conference interview with the Clinical Coordinator.
- Individual video conference interviews with Employment, Peer Support, ACT, and two Co-Occurring Specialists.

- 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 staff and Co-Occurring Specialists' staff; ACT team member roster; Natural Support tracking tool; cover page of the *Integrated Dual Disorders Treatment, Recovery Life Skills Program* manual; Co-Occurring member roster; sign-in sheets for co-occurring disorder treatment groups for the month prior to the review; Co-Occurring members' calendars for the month prior to the review; *COS Tracking Spreadsheet*; *Valleywise ACT Team Clinic Contact List* and *Riverview ACT Clinic business card*; and the ACT Brochure.

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 three 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 team is of sufficient size to provide coverage to the 91 members. The team has a member to staff ratio of 8:1.
- A team approach is used when delivering services to members in the community. Team staff know all members and share responsibility for each member, with 90% of members having contact with more than one staff in a two-week period.
- The team, including the Psychiatrist, meets four days a week to discuss members. During the meeting observed, multiple staff contributed to the discussion by reporting on recent and planned contacts with members.
- The ACT Psychiatrist is fully dedicated to the ACT team, with no outside responsibilities, and is accessible to staff and members including after hours and weekends. Additionally, the Psychiatrist provides services in the community, including hospital visits.
- Noticeable improvement of community-based service delivery. Continue efforts to achieve a goal of 80%.

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

- Increase support to members that receive a lower intensity and frequency of service. The ACT team should provide members an average of two hours of in-person service delivery and an average of four or more in-person contacts weekly.
- Increase delivery of structured individual and group substance use treatment services. Records lacked evidence of a high rate of individualized and group substance use treatment delivery. Continue efforts to engage members with a co-occurring disorder to participate in treatment based on their stage of change and ensure documentation of that service occurs.
- Increase contacts with natural supports to an average of four per month for each member with a support system. Continue efforts to involve natural supports in member care.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, there were 11 full-time equivalent (FTE) staff, excluding the Psychiatrist, Medical Assistant, and administrative staff. The team provides direct services to 91 members with an appropriate member-to-staff ratio of 8:1. Full-time direct service staff included the Clinical Coordinator (CC), two Nurses, two Co-Occurring Specialists (COS), an Employment Specialist (ES), Rehabilitation Specialist (RS), Team Specialist (TS), Independent Living Specialist (ILS), Peer Support Specialist (PSS), and Housing Specialist (HS).	
H2	Team Approach	1 – 5 5	Staff interviewed reported 80 – 90% of members have contact with at least two ACT staff each week. Staff reported carrying a caseload for administrative purposes only and that all direct staff provide services to all members on the team. The team tracks contact with members during the program meeting and staff discuss which members will be seen that week and when. During the program meeting observed, at least two staff reported meeting or were scheduled to meet with each member for that week. All members interviewed reported seeing more than one staff in a two-week period. Per review of ten randomly selected member records, for a two-week period, 90% of members received in-person contact from more than one ACT staff.	

H3	Program Meeting	1 – 5 5	Based on staff interviews, all members are discussed in the program meeting that is held four days a week, Monday, Tuesday, Thursday, and Friday. All staff are expected to attend on days they are scheduled to work, including the Psychiatrist. The team meets on Wednesdays for two hours to update treatment plans, in-depth discussion on hospitalized members, and are provided additional training and clinical supervision. During the meeting remotely observed, the CC led the discussion by reviewing all members on the ACT roster utilizing member calendars. All staff provided input on recent member and natural support interactions, including attempts and planned contact for the week, discussions of members' hospitalization status and contacts made, and members that attended or were scheduled to attend groups at the clinic were identified. Outreach assignments and mechanisms were discussed amongst staff, as well as ACT employment support for at least four members, and on-call staff reported after-hours activities and follow-up plans discussed. COS staff reported on the next scheduled individual substance use treatment sessions with members, along with the CC discussing members engaged in individual counseling and reporting on members that were planning to begin individual counseling with the CC.	
H4	Practicing ACT Leader	1 – 5 3	The CC estimated delivering in-person services to members 10% of the time. The CC reports assisting with medication observation, basic case management, and provides general counseling	• Continue efforts to provide in-person services to members. Optimally, the ACT CC delivers direct services to members and

			services to members on the team. In ten records reviewed there were three examples of the CC delivering services over a recent month. All members interviewed reported meeting with the CC recently, one member interviewed reported receiving individual counseling by the CC weekly. Based on review of the CC's productivity report for a four-week period, the CC provided direct services 15% of the time.	should account for at least 50% of the expected productivity of other ACT staff. • Identify administrative tasks currently performed by the CC that may be transitioned to other administrative or support staff, if applicable.
H5	Continuity of Staffing	1 – 5 4	Based on the information provided, three staff left the team since the last review (December 2021), resulting in a turnover rate of 25%. (Calculation adjusted for shorter period between reviews.)	• Ideally, turnover should be no greater than 20% over a two-year period.
H6	Staff Capacity	1 – 5 4	The team operated at 91% of staff capacity during the prior year. The ES position was vacant for five months. The HS has been on extended leave since the beginning of November 2022 and the position is considered vacant for this item only.	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually.
H7	Psychiatrist on Team	1 – 5 5	The team has one FTE Psychiatrist that works four 10-hour days a week, Tuesday through Friday, and attends the program meeting on those days. Staff reported the Psychiatrist only sees members of this ACT team and is accessible to the team in person, by phone, and email, including after hours and weekends. Staff and members interviewed stated the Psychiatrist is very involved in member care. One staff reported the Psychiatrist strives to embrace and help members be the best they can be. During the program meeting, the Psychiatrist stated plans to complete a hospital visit with a member over the weekend to assess for discharge and to ensure care coordination with the inpatient	

			team. All members interviewed indicated using the ACT Psychiatrist to acquire their medication(s) and reported meeting with the Psychiatrist at least once a month. In addition, all members interviewed provided unsolicited positive comments related to the care received from the Psychiatrist. One member reported the Psychiatrist provided individual trauma therapy to them in the last year.	
H8	Nurse on Team	1 – 5 5	The ACT team has two Nurses to support the care of the 91 members. Each work four 10-hour workdays providing coverage Monday through Friday to members on the team. Staff report the Nurses are available after hours and weekends to consult and provide leadership to the team. Aside from attending daily program meetings, the Nurses provide medical support, medication oversight, administer injections, and medication observations in the community including coaching members on independent medication skills. Each Nurse carries a caseload of members with complex medical needs. Members interviewed reported seeing the Nurses in the clinic weekly to monthly with home visits arranged as needed.	
H9	Co-Occurring Specialist on Team	1 – 5 5	The team is staffed with two full-time COS. One COS has been in the role since 2020, and the second COS joined the team in December 2021. Training records provided showed one COS completed one training: *Substance Use Treatment and Relapse Prevention for Racial and Ethnic Minorities* since the last review. The second COS attended nearly seven hours of training in harm reduction, screening and intervention, stimulant	• Continue to provide COS with supervision by qualified staff, annual training, and guidance in co-occurring treatment best practices. Optimally, consistent evidence-based co-occurring treatment information is provided and then disseminated, through cross training, to other ACT staff.

			disorders, and how racial and ethnic minorities are impacted by substance use disorders. Yet, neither had training since the last review in co-occurring disorders treatment delivery. Both COS receive monthly individual supervision by the CC, a Licensed Associate Counselor, and are provided direction during the program meeting as needed by the Psychiatrist.	
H10	Vocational Specialist on Team	1 – 5 4	The team has two Vocational Staff. The Rehabilitation Specialist joined the team in October 2022, and the Employment Specialist has been on the team since August 2021. Staff reported both Vocational Staff attend the employment related Mercy Care quarterly meetings. Training records provided showed both Vocational Staff receiving Disability Benefits 101 training since the last review. No other training related to assisting members in finding employment in an integrated setting was located in training records provided since the last review.	• Ensure that both vocational staff receive regular training in assisting people diagnosed with a serious mental illness (SMI)/co-occurring disorder to find and retain employment in integrated work settings.
H11	Program Size	1 – 5 5	At the time of the review, the team was composed of 12 staff, an adequate size to provide necessary staffing diversity and coverage.	
O1	Explicit Admission Criteria	1 – 5 5	Staff interviewed reported members are referred by the Regional Behavioral Health Authority, crisis response provider, and other providers. The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. The CC conducts most of the screenings, although the TS and other seasoned staff will assist with screenings as needed. A review of the member's chart is completed, and the Psychiatrist will coordinate with the treating doctor to gather additional information. Together the CC and Psychiatrist	

			make the final decision if the member is appropriate for the team.	
O2	Intake Rate	1 - 5 5	Per data provided, and reviewed with staff, the ACT team has an appropriate rate of admissions with less than six members per month admitted to the team. The ACT team accepted a total of five admissions over the previous six months, with no more than one admission monthly.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services, substance use treatment, counseling/psychotherapy, and employment and rehabilitation services. Based on staff interviews, the team has more than 10%, 13 members, residing in settings where ACT services are duplicated. A review of 10 member records showed five members residing in staffed settings.	• Continue to track the number of members in staffed residences. As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team. Optimally, no more than 10% of ACT members are in settings where other social service staff provides support.
O4	Responsibility for Crisis Services	1 – 5 5	Based on interviews, the ACT team is available to provide crisis services 24 hours a day, seven days a week. Staff provided a copy of the *Riverview ACT business card* given to members and natural supports that lists the main ACT team line, on-call number, backup on-call, and Veyo transportation. The team also provides members the *Valleywise ACT Team Contact List* that includes the main line, on-call, backup on-call and the numbers for each specialist position, Nurses, and the CC. Staff interviewed reported carrying the laminated business cards with them to provide to members to ensure they are informed of the team's availability.	

			Staff rotate on-call duties weekly with a primary and secondary on-call. The ACT CC is the third in line as identified back up. All members interviewed were familiar with the ACT on-call services and two reported having used it in the past. When staff respond to crisis calls after hours and weekends, staff will attempt to de-escalate the member over the phone. When further assessment is needed, or the situation cannot be handled over the phone, staff will go into the community to meet the member where they are at.	
O5	Responsibility for Hospital Admissions	1 - 5 4	Staff reported when a member is experiencing an increase of symptoms or requesting to be psychiatrically hospitalized the team will go out into the community to assess the member, will then staff the situation with the CC, and will offer for the members to be triaged by the Psychiatrist or Nurses. When the recommendation is for inpatient care, the team will ask the member which hospital they prefer. The team will transport the member, coordinate with the inpatient team, and wait with the member until admitted. Staff interviewed indicated the team will meet in-person with the member within 24 hours of admission and every 72 hours. A doctor-to-doctor call is completed upon admission. In-person staffings are held once weekly with the ACT team, members, and inpatient team. For members that self-admit to psychiatric hospitals, the team begins coordination of care with the inpatient team and meets with the member in-person within 24 hours of being notified.	• 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. • Consider if member treatment plans should be revised to address behaviors and/or circumstances related to self-admissions.

			Based on data provided and reviewed with staff, the team was directly involved in eight out of the ten most recent member psychiatric hospital admissions which occurred in a two-month period. Both members self-admitted. One of those members voluntarily admitted into an inpatient facility despite the team's coordinated efforts with an out of state entity.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff interviewed reported discharge planning begins upon admission. Staff identified following a five-day protocol with members upon psychiatric hospital discharge that includes in-person contact daily for five days. A team approach was observed during the program meeting for members that were inpatient or discharged as diverse staff were assigned hospital visits and five-day follow up utilizing the member calendars. Members are scheduled with the Psychiatrist within 72 hours of discharge. Staff will transport members when discharged to the clinic, or to their home. Some members' staffed residences will request to discharge and transport the member to their location, staff will complete the five-day follow up. Based on data provided and reviewed with staff, the team was directly involved in nine out of ten most recent hospital discharges which occurred in a three-month period. One member discharged themselves, or possibly to a natural support, and then the team was notified. As reported by staff interviewed, five-day follow up with all ten members was attempted and/or completed, and all ten members were scheduled with the Psychiatrist within 72 hours of discharge. Five	• Continue to develop plans with members, inpatient staff, and/or natural supports in advance pertaining to discharge planning.

			members missed the original date scheduled with the Psychiatrist, however, were rescheduled.	
O7	Time-unlimited Services	1 - 5 5	Staff interviewed reported discussing members with the clinical team that no longer require intensive services. Discussions with members regarding reduced contact occur for those wanting to step down to a lower level of care. The team identified the importance of respecting member choice when a request is made to a lower level of care, to limit contact with the team, or to remain on the team as some members are fearful of decompensation when not having the support of the ACT team. Data provided to reviewers showed the ACT team served 104 members in the past 12 months. Five members graduated during this timeframe. Staff interviewed reported that the team anticipates graduating one member in the next year.	
S1	Community-based Services	1 - 5 4	Staff interviewed reported 65 – 85% of in-person contacts with members occur in the community. In ten member records, a median of 65% of services occurred in the community over a recent month period. All ten records reviewed had at least one community contact. The member with the highest number of contacts with staff was seen in the community almost 95% of time. Documented community visits in records reviewed were at members' residences, jail, grocery store, local coffee shop, and a fast-food restaurant. During the program meeting observed, staff reported taking members to local food establishments for a meal and planning a day to take a member to play basketball in the community. All members interviewed reported seeing staff in the clinic	• Continue efforts to increase the delivery of services to members in their communities. For members that prefer groups, determine if the activity can be transitioned to a community setting.

			more often than their home or community. Art group at the clinic was identified by members interviewed as well liked and attended weekly.	
S2	No Drop-out Policy	1 – 5 5	According to data provided, the team retained 96% of the members in the last 12 months. One member could not be located.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff interviewed reported that when the team does not have contact with members, outreach efforts begin within one week of no contact, if not sooner. Outreach is conducted four times a week which includes two physical and two “call circle” efforts. Staff reported the team’s approach to outreach and engagement efforts include going to the member’s last known address, where the member is known to hang out in the community, shelters, natural supports, probation officers, and payees. Staff described the “call circle” as twice weekly contact with several entities such as hospitals, jails, medical examiner’s office, and natural supports. One member record reviewed showed evidence of the “call circle” effort being completed. During the program meeting observed, staff provided updates on outreach efforts for multiple members including outreach methods utilized per staff interviews. One member missed two appointments with the Psychiatrist, including the morning of the observed program meeting. The Psychiatrist requested the team travel to the member’s home that day to check in with the member. During the program meeting, the Psychiatrist was contacted by the member via phone call/text message that they had lost their phone and will be at the clinic the following day. One member interviewed reported meeting	

			weekly with ACT staff via videoconference while on vacation and was appreciative of the continued contact. Another member reported losing phone service for two days, and that the team called their family to check on their wellbeing when the team could not get in touch with the member.	
S4	Intensity of Services	1 – 5 2	Per a 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 44.75 minutes. The highest rate of intensity was 105.25 minutes a week, and the lowest member record reviewed indicated a rate of intensity of 21.50 minutes a week. Records reviewed indicated a median of 2.25 hours of phone contact with members and one member record showed delivery of services through videoconferencing. *The fidelity tool does not accommodate delivery of telehealth services.*	• Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. Provide individualized support, including to members that elect not to participate in clinic-based groups. The ACT team should provide members an average of 2 or more hours of in-person contact weekly. • Ensure the team is assisting members in working on recovery goals as identified. By using *motivational interviewing*, and other techniques, the team can assist members to identify meaningful recovery goals and then offer the supports and services to members to reach those goals.
S5	Frequency of Contact	1 - 5 3	Of the ten records randomly sampled, ACT staff provided a median frequency of 2.63 in-person contacts to members per week. Three members charts reviewed had four or more in-person contacts a week.	• Continue efforts to increase the frequency of contact with members by ACT staff, preferably 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.
S6	Work with Support System	1 – 5 3	Per staff report and data provided, approximately 83 members have a natural support. Natural support contacts are identified and tracked during the program meeting. During the program meeting	• The ACT team should have four or more contacts per month for each member with a community support system. Ensure consistent documentation of contacts with

			observed, contact with natural supports were identified for at least 17 members. Per members interviewed, the team has contact with their natural supports. Of those responses, one member reported frequently, another reported when the team was not able to reach them, and the other reported only when it is a crisis situation. Per natural support data provided by the team, nine out of ten member records reviewed were identified as having natural supports. However, only two charts had documentation of natural support involvement. One record had 14 contacts documented and the other had 3 in the month period reviewed.	natural supports occurs, which includes contact by phone, email, and text, as well as in-person.
S7	Individualized Co-Occurring Disorder Treatment	1 - 5 3	Per interviews and data provided, there are 64 members on the team identified with a co-occurring disorder. Staff reported that approximately 51 members receive individual co-occurring disorder treatment 4 – 5 times a month, ranging from 10 – 30 minutes per session. Staff reported sessions are structured around SAMHSA materials, utilizing the Integrated Co-Occurring Disorders Treatment (ICDT) model, harm reduction, and motivational interviewing strategies. The COS utilize a *COS Tracking Spreadsheet* to identify members names, substance use diagnosis, stage of change, stage of treatment, participation in individual or group treatment, preferred contact day(s) of the week, and whether the member is engaged in COS treatment. Yet, does not identify sessions, duration, or groups attended. Seven member charts reviewed had a co-occurring diagnosis. Four had documentation of COS engagement with the member ranging from twice	• Continue efforts to provide an average of 24 minutes, or more, per week of formal individualized substance use treatment services for all members with a co-occurring diagnosis. • If not done so already, consider reviewing documentation of individual treatment services provided during supervision with COS to ensure identification, in sufficient detail, of services delivered and that services align with the members' stage of change. Documentation should reflect formalized substance use treatment interventions and differentiate from case management related services provided.

			a week to once a month for duration of 5 – 21 minutes per encounter. Although, documentation identified informal queries of substance use rather than structured individual substance use treatment delivery. Actual time spent providing formalized individual substance use treatment was unclear, per member calendars provided and charts reviewed.	
S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	Staff interviewed reported two co-occurring disorder treatment groups are offered to ACT members weekly: one for earlier stages of change, and one for later stages of change. Reviewers were provided a cover page of the *Integrated Dual Disorders Treatment, Recovery Life Skills Program* group workbook utilized. Staff reported approximately 8 - 10 unique members attend the earlier stages of change group, and 4 – 10 unique members attend the later stages of change group weekly. Once a month a co-occurring treatment group is delivered in the community. Staff reported that the maximum number of members that can attend any group is 10 due to continued agency efforts for social distancing. Based on review of co-occurring diagnosis treatment group sign-in sheets for the month prior to the review, 10 ACT members with a co-occurring diagnosis attended at least one co-occurring disorder group. Of the seven member records reviewed that were identified by the team with a co-occurring diagnosis, none were located on the sign-in sheets for the month prior to the review.	• Optimally, 50% or more of members with a substance use disorder attend at last one co-occurring disorder treatment group each month. • All ACT staff should engage members with a co-occurring diagnosis to participate in treatment groups based on their stage of change.

S9	Co-Occurring Disorders Model	1 – 5 3	Most staff interviewed reported supporting members in reducing use of harmful substances and were able to provide examples of tactics used. In addition, staff reported meeting members "where they are at" in recovery utilizing motivational interviewing. One staff reported that if a member's goal is abstinence, the team will honor personal choice, however, encourages reduced use in a harm-reduction approach. Another staff reported preferring abstinence to alter members' behaviors, adding that the initial goal is harm reduction with the final outcome of "sobriety". Staff reported members are not referred by the team to peer-run substance use programs but will support members that request to attend. When members request detoxification services, the team will refer them to local resources as clinically indicated. Some staff interviewed were not familiar with the principles of a stage-wise treatment approach to interventions and reported reliance on the COS to provide best practices when working with members with a co-occurring disorder. Staff reported members' stage of change and stage of treatment is discussed 2 to 3 times a week with the team during the program meeting, this was not seen during the meeting observed. Staff interviewed reported receiving training through Relias, and reported additional trainings were provided more often prior to the public health emergency. Interviews indicated ACT staff have received Narcan training, and all specialists carry Narcan to provide to members.	• 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. • Ensure all specialists are regularly offering or providing stage-wise, recovery oriented, substance use engagement to members with a COD based on their treatment goals. • Continue regular discussions regarding members' co-occurring disorder treatment needs, the stages of change, and appropriate stage-wise interventions to utilize in supporting individual members in moving toward their recovery goals.

			Based on the seven records reviewed of members with a co-occurring diagnosis, all seven treatment plans reflected a goal related to substance use treatment, however, only two identified interventions how the team would support the member in moving toward their recovery goal. Plans seemed to primarily be focused on frequency of service delivery, rather than the services and framework of the services delivered.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has one Peer Support Specialist (PSS) assigned to the team. The PSS shares their story on a targeted basis when it would benefit the member. Staff interviewed identified from one or five additional staff with lived or family experience. It was unclear if other staff share their personal stories. Two of the three members interviewed knew the staff in the role of the PSS and the other member knew there should be a PSS on the team but could not identify the staff person. One member shared that additional staff have shared their personal family experience and that has assisted the member in their own recovery and increased trust of that staff member.	
	Total Score:	**117**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
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	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	4
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	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
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	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.18**	
Highest Possible Score	**5**	