ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

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To: Dan Ranieri, Chief Executive Officer
Courtney Bradford, Clinical Coordinator

From: Madison Chamberlain, BS
Allison Treu, BS
AHCCCS Fidelity Specialists

Introduction

The Arizona Health Care Cost Containment System (AHCCCS) contracts with the Western Interstate Commission for Higher Education (WICHE) 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) that uses a multidisciplinary team approach to provide comprehensive, community-based behavioral health services to individuals designated as having a Serious Mental Illness (SMI).

Method

On July 13 – 15, 2026, Fidelity Specialists conducted a review of the **La Frontera-EMPACT: Comunidad ACT Team**. This report provides targeted feedback on the implementation of the agency's ACT services to support quality improvement and strengthen the delivery of behavioral health services in the community.

La Frontera-EMPACT operates multiple outpatient clinics that in addition to providing Assertive Community Treatment also provides a range of behavioral health services including crisis services, suicide prevention and postvention, trauma healing, and child and family treatment. While the program may use varying terminology to describe individuals receiving services, this and other fidelity review reports use the term "member" to support clarity and consistency.

The SAMHSA ACT Fidelity Review tool does not specifically account for telehealth service delivery. An exception has been made for psychiatric prescriber services due to workforce shortages and limited availability of psychiatric providers in Arizona.

This review was conducted remotely using videoconferencing and telephone to observe meetings and conduct interviews with staff and members.

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

- Remote observation of an ACT team program meeting on July 14, 2026.
- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with the Housing, Vocational, ACT, and Peer Support Specialists, and two Co-Occurring Disorder Specialists for the team.
- Individual telephone interviews with members receiving services from the ACT team. Three of the five members identified were successfully interviewed.
- Closeout discussion with the Clinical Coordinator, ACT Program Manager, and representatives from the contractor with a Regional Behavioral Health Agreement (RBHA).
- Review of medical records for 10 randomly selected members using the agency's electronic health record (EHR) system. The sample included only members enrolled in a health plan with the contractor with a Regional Behavioral Health Agreement.
- Review of documents: *Mercy Care ACT Admission Criteria,* member calendars; Clinical Coordinator direct service productivity report; copies of cover pages of substance use disorder treatment materials utilized including: *SAMHSA Integrated Treatment for Co-Occurring Disorders*, *Living in Balance* (Hazelden), and *Substance Abuse Treatment and The Stages of Change* (DiClemente); co-occurring disorders treatment group sign-in sheets; natural support group sign-in sheets; and resumes and training records for Vocational and Co-Occurring Disorders Specialist staff.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how closely a team implements the ACT model using specific observational criteria. The scale measures fidelity to the ACT model across three (3) dimensions: Human Resources, Organizational Boundaries, and Nature of Services. The ACT Fidelity Scale consists of 28 program-specific items. Each item is rated on a five-point scale, ranging from one (1), meaning *not implemented*, to five (5), meaning *fully implemented with little room for improvement*.

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 and Key Recommendations

The program demonstrated strengths in the following areas:

- Practicing ACT Leader: The team has significantly improved in this area since previously being reviewed. At the time of the review, the Clinical Coordinator accounted for 44% of the team direct service productivity. Continue supporting the Clinical Coordinator by delegating appropriate administrative and non-clinical responsibilities to other team members, ensuring at least 50% of the coordinator's time is dedicated to direct service delivery.
- Staff Capacity: At the time of the review, the team operated at 99% capacity and had only one position vacant for one month in the past 12 months. Adequate staffing capacity enables the team to provide frequent, individualized, and flexible services that are responsive to member needs.
- No Drop Out Policy: The team demonstrated high member retention and maintained 99% of its roster in the past 12 months.

- Co-Occurring Disorders Model: The team uses a non-confrontational, stage-based approach that supports individualized, gradual progress toward recovery based on the current stage of change for each member.

The following program areas will benefit from focused quality improvement efforts:

- Team Approach: Increase the percentage of members who receive contact from diverse team staff within a two-week period, with the goal of reaching 90% of members. Working with diverse staff with different expertise can improve member engagement and continuity of care. Per the records reviewed, 50% of members received in-person services from more than one staff in a two-week period.
- Community-based Services: Increase community-based services so that 80% or more of services occur in member's communities. ACT serves populations that have historically been less successful in traditional office or clinic-based services. Staff provided community-based services 52% of the time based on the records reviewed.
- Frequency of Contact: Increase the frequency of contact delivered to members, ideally averaging four (4) or more in-person contacts a week. Evidence has shown improved outcomes for members with more frequent contact and services. Per the records reviewed, the team provided a median frequency of 1.63 in-person contacts to members per week.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, the team had 11 full-time equivalent (FTE) staff, excluding the Psychiatrist, serving 99 members. The team had an appropriate member-to-staff ratio of 9:1. The team included two Co-Occurring Disorders Specialists, two Registered Nurses, a Rehabilitation Specialist, an Employment Specialist, a Housing Specialist, an Independent Living Specialist, a Peer Support Specialist, an ACT Specialist, and a Clinical Coordinator.	
H2	Team Approach	1 – 5 3	Staff reported rotating assigned regions daily to increase the likelihood that members receive contact with more than one team staff each week. Staff have assigned caseloads for tracking member's annual documentation updates and assessments. However, staff reported sharing responsibility for providing direct services to all members on the roster. All three of the members interviewed reported seeing more than one staff in a two-week period. Of the 10 randomly selected member records reviewed, for a month period, 50% received in-person contact from more than one staff from the team in a two-week period.	• Increase contact of diverse staff with members such that 90% have contact with more than one ACT staff every two weeks. ACT team staff are jointly responsible for making sure each member receives the services needed to support recovery from mental illness. Diversity of staff interaction allows members access to the unique perspectives and expertise of staff, as well as the potential to reduce the burden of responsibility for member care on staff.
H3	Program Meeting	1 – 5 5	The team meets in person to review service needs for all members four days a week. All staff attend program meetings on scheduled	

			workdays. The Psychiatrist attends all four meetings. During the observed meeting all members were reviewed. Staff discussed recent and planned member contacts, the current stage of change for members, treatment interventions, outreach and contact strategies, recent natural support communication, and upcoming appointments. The Clinical Coordinator facilitated the meeting, and the Psychiatrist provided recommendations regarding member interventions.	
H4	Practicing ACT Leader	1 – 5 4	The Clinical Coordinator has held this position since July 2024. Staff reported that the Clinical Coordinator provides 50-60 hours of direct services to members per month. Examples of direct services provided by the Clinical Coordinator included accompanying members to psychiatric appointments, back-up coverage for on-call crisis services, and providing skills training in the community. The productivity expectation of other team staff is 115 hours of direct services per month. Per the recent productivity report provided, the Clinical Coordinator accounted for 44% of the team direct service productivity. Of the 10 randomly selected member records, the Clinical Coordinator documented providing direct services in three records. Notes included the Clinical Coordinator attending appointments alongside members, in-person hospital staff meetings, and discharge planning. Two records had evidence of the Clinical Coordinator	• Support ACT leaders to provide direct care to members equal to or greater than 50% of the time expected of other ACT staff. Transfer responsibilities not necessary to be conducted by the ACT leaders to administrative or other ACT staff.

			providing services by phone or videoconference to members. *The fidelity tool does not accommodate delivery of telehealth services.* *This item is dependent on provider productivity expectations.*	
H5	Continuity of Staffing	1 – 5 5	Based on information provided, and reviewed with staff, the team has experienced a turnover of approximately 8% during the past two years. The team had two staff leave the team, an Employment Specialist and a Registered Nurse.	
H6	Staff Capacity	1 – 5 5	In the past 12 months, the team has operated at approximately 99% of the full staffing capacity. The team only had one month of a position being vacant which was the Housing Specialist.	
H7	Psychiatrist on Team	1 – 5 5	The team has a Psychiatrist that is responsible for all member's psychiatric evaluations and psychiatric medication prescriptions and provides the team with clinical direction regarding appropriate interventions for member care. The Psychiatrist primarily provides in-person appointments in the clinic but will also provide videoconference or in-person visits in the community, when needed. Members are seen by the Psychiatrist at least monthly or more frequently if clinically indicated. The Psychiatrist is available to the team four days a week, 10 hours a day and is accessible by phone or messaging applications, or in-person. Staff reported that the Psychiatrist is also available after business hours or on the weekends, if needed. The Psychiatrist is fully dedicated to the ACT team.	

			There was evidence within 60% of member records of members seeing the Psychiatrist.	
H8	Nurse on Team	1 – 5 5	The team is served by two full-time Registered Nurses (Nurses). Primary nursing responsibilities on the team include assisting with physical health referrals, nursing assessments, delivering injections, helping with medication adherence and labs both in the clinic and in the community if needed. The Nurses are accessible to the team by phone, messaging applications, and calendar invites to coordinate appointment scheduling and transportation for members. The Nurses are fully dedicated to the ACT team.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 4	There are two Co-Occurring Disorders Specialists that have been with the team since 2015 and 2023, respectively. One specialist completed 1.25 hours of relevant substance use treatment training. The other specialist completed over eight hours of relevant training. Neither Co-Occurring Disorders Specialist receive dedicated clinical supervision from a licensed professional.	• Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions (e.g., a stage-wise approach and the evidence-based practice of harm reduction). (See AMPM Policy 930 – Implementation and Fidelity Monitoring of SAMHSA Evidence-Based Practices.) The CODS supports the team by cross-training staff and guiding interventions based on the members' stage of change and the co-occurring disorders model adopted by the team. • Ensure Co-Occurring Disorders Specialist staff are provided with regular supervision from a qualified professional to support delivery of individual and group substance use treatment services

				in an integrated treatment model approach.
H10	Vocational Specialist on Team	1 – 5 3	The Rehabilitation Specialist has served the ACT team in that role since 2015 and the Employment Specialist since 2021. Neither the Rehabilitation and Employment Specialist had training related to vocational or employment support in the past 12 months.	• Provide ongoing training, guidance, and supervision to Vocational Specialist staff, including at least four (4) hours of annual training focused on employment and vocational support services. Training should emphasize best practices that help members obtain competitive jobs in integrated settings.
H11	Program Size	1 – 5 5	At the time of the review the team had 12 full-time staff, including the Psychiatrist, and no vacant positions and was adequately staffed to provide services to members.	
O1	Explicit Admission Criteria	1 – 5 5	Reviewers were provided with the *Mercy Care ACT Admission Criteria* staff reported utilizing to screen potential members for eligibility. Staff identified examples of target populations for ACT services including qualifying diagnoses, high recidivism and utilization of crisis services. The Team Lead and Rehabilitation Specialist are responsible for conducting screenings with members. Staff reported conducting up to three screenings and discussions with potential new members to ensure they are informed of the frequency, intensity, and types of services provided by ACT to see if members still are interested in joining the team. The ACT Psychiatrist has the final say if members are eligible for admission. All members admitted to the team are expected to receive all services, including psychiatric medication and evaluation services from the team Psychiatrist.	

			Referrals to ACT services are received internally from within the agency, and externally by Mercy Care, and higher levels of care (e.g., state hospital).	
O2	Intake Rate	1 – 5 5	The team accepted a total of six new members during the past six months, with no more than two admissions per month. June and March 2026 each had two intakes and were the months with the highest admission rate.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team is credited with providing psychiatric services and medication management, and substance use treatment. The team was not credited for the following services: Counseling/psychotherapy: At the time of the review, there were no licensed staff or a clinical master's level intern providing counseling or psychotherapy on the team. Approximately three members were receiving counseling services off the team from an agency licensed staff. Employment/rehabilitative: More than 10% of members were receiving outside employment services such as job coaching and work adjustment training. Staff reported coordinating at least monthly with outside providers to support members receiving outside services. The team will support members interested in work, school, or volunteering by completing vocational profiles, taking members to tour schools or peer-run facilities, providing benefits counseling, and	*In the evidence-based practice of ACT, all member services are delivered by the ACT team. As a transdisciplinary service delivery model, area specialists are trained and cross trained to provide the core components of ACT: case management, psychiatric services, counseling/psychotherapy, employment and rehabilitation services, housing support, and substance use treatment.* • Make counseling/psychotherapy available to members on the team provided by clinically licensed ACT staff. This staff will also act as a generalist within the team. • Ensure vocational services are delivered by ACT team staff in alignment with the EBP. Vocational staff receive training to support members with SMI and co-occurring disorders in obtaining and maintaining competitive employment and, in turn, cross-train other team specialists. Additionally, collaborate with outside entities, such as Vocational Rehabilitation Services, to clarify that employment services are to be provided

			connecting members with transportation resources. Housing: Approximately 11 members lived in settings with on-site non-ACT staff such as residential facilities, staffed group or recovery homes, and assisted living. Housing services provided on the ACT team included assisting members complete housing applications and independent living skills training.	within the ACT team and that external referrals for job search and support are not consistent with the ACT model. • Continue to monitor 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 in which all housing support and case management responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all the services and support from the team.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides crisis services to members 24 hours, seven days a week, through on-call crisis services provided by the team. On-call responsibilities are rotated daily between staff, and the Clinical Coordinator serves as the back-up on-call if the assigned staff are unavailable. When members contact the on-call number, staff will attempt to de-escalate over the phone and when unsuccessful, will go into the community to assess the member in-person. Members are provided with business cards with staff contact information and on-call services at intake. Staff reported reminding members of on-call services for members that tend to self-admit to hospitals and post the on-call number on member's refrigerators.	

			Of the three members interviewed, one member reported awareness of the 24-hour on-call crisis services and another member reported they would call staff directly in the event of an urgent issue after-hours.	
O5	Responsibility for Hospital Admissions	1 – 5 3	When members are in crisis, staff and the Nurses will transport members into the clinic to be assessed by the Psychiatrist. If the Psychiatrist suggests hospitalization, then the Psychiatrist will coordinate admission to the hospital of choice of the member. Staff will transport members and provide support through the evaluation and hospital admission. Staff will also coordinate involuntary admission (e.g., amendment to existing court ordered treatment or petition for involuntary treatment). Per review of data with staff relating to the ten most recent psychiatric hospital admissions, which occurred over a four-month time frame, the team was directly involved in 60%. For the admissions the team were not directly involved, members either self-admitted to the hospital without notifying the team, the member's residential facility staff took the member to the hospital without seeking team interventions, or the team was alerted after the admission. One of the records reviewed had evidence of the team assisting a member in crisis by de-escalating in-person and coordinating the member's transport to an inpatient unit and providing medication lists to inpatient providers. Another record showed that the team was not	• ACT teams performing to high fidelity of the model are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. • Consider revisions to member treatment plans to address behaviors and/or circumstances related to not involving the team when admitting to a psychiatric hospital (self-admission). • 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, and their supports, on how the team can provide aid prior to and during admission, especially for members with a history of seeking hospitalization without team support.

			directly involved in admission and were notified after the member's hospitalization.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Once a member is admitted to the hospital, staff reported that coordination with inpatient providers begins right away by providing inpatient providers with psychiatric notes and medication lists. Staff reported meeting with inpatient staff and members every two to three days while a member is inpatient. Staff will meet with the inpatient staff and member for discharge planning and ensure a member is discharged to a place of their choice. Once a member is discharged from the hospital, staff will transport them directly to their placement or coordinate with natural supports for transport. Members are scheduled to see the Psychiatrist within 72 hours of discharge. Staff reported that members also receive approximately two to three daily in-person follow-up appointments by staff within a week of discharge. Per the review of data with staff relating to the last ten psychiatric hospital discharges, the team was directly involved in 100%.	
O7	Time-unlimited Services	1 – 5 5	In the last 12 months, zero (0) members have graduated from the program. In the next year, three members are expected to graduate.	
S1	Community-based Services	1 – 5 3	Staff interviewed reported that 80% - 85% of in-person contacts with members occurs in the community. Results of 10 randomly selected member records reviewed show staff provided services with a median of 52% of the time in the community. Community-based services seen in	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in communities where members live. • For members that come into the clinic multiple times a week, explore how to

			records were individual and group-based life skills training, wellness checks within the member's home, responding to crises, hospital visits, and individual substance use counseling within member's residence and community.	deliver those services in natural settings where members live.
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had one member that dropped out of the program in the past year that was justice-involved. The team retained 99% of the total number of members served in the past 12 months. Not included in this count were one member death, three members that transitioned to higher level of medical care, and one ACT transfer with referral.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The team utilizes the *Mercy Care ACT Manual: Assertive Engagement Mechanisms* protocol of when the team is unable to contact a member. Per the protocol the team is responsible for completing four outreach attempts a week, including community-based outreaches to locate the member, for a minimum of eight weeks before discharging a member from the team. Staff reported considering multiple factors before closing a member even beyond eight weeks of outreach attempts and will keep members enrolled in services if there is a history of members returning after long lapses of services. In the observed program meeting, there was evidence of staff reporting the week of outreach, the number of outreach attempts, and the planned contact strategy for re-engaging the member.	• When members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. It is essential to discuss and monitor engagement efforts during the program meeting to prioritize team activities. Consider peer review of documentation to ensure efforts are accurately included in member records. • Ensure all outreach efforts, including letters, phone calls, and contact with formal and natural supports are documented in member records.

			Three records had evidence of attempted re-engagement with members including staff attempting home visits and phone calls with the member, visiting locations members are known to frequent (e.g., gas stations) and speaking with natural supports. Staff reported building rapport with members and providing resources such as bus passes and food to help members stay engaged in services. Four of the member records, had over eight days of no documented contact or outreach attempts by the team. Two of those four records had 13 days of no documentation.	
S4	Intensity of Services	1 – 5 3	Per a review of 10 randomly selected member records, during a month period before the fidelity review, the median amount of time the team spends in-person with members per week is approximately 77 minutes. Services intensity across records ranged from no in-person contact to approximately 327 average minutes of direct services per week.	• Increase the duration of services delivered to members. ACT teams provide an average of two (2) or more hours of in-person services per week to help members with serious symptoms maintain and improve functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms. • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly.
S5	Frequency of Contact	1 – 5	Of the 10 randomly sampled records, ACT staff provided a median frequency of 1.63 in-person	• Identify and resolve barriers to increasing contacts with members. Optimally,

		2	contacts to members per week. The record with the highest average in-person contacts per week was 8.25 contacts. One record had zero in-person contact.	members receive an average of four (4) or more in-person contacts a week. • Improved outcomes are associated with frequent contact. Members of ACT teams find limited success with traditional office-based treatment and often require more frequent community contact to be assessed for current needs and to receive ongoing support. On ACT teams, all staff are invested in delivering a high frequency of contacts with members, and contacts are individualized, aligning with members' recovery goals. • Avoid over-reliance on groups or office-based services to achieve contact. On ACT teams, services are individualized to meet the needs of each member.
S6	Work with Support System	1 – 5 4	Per the data provided and reviewed with staff, approximately 41% of members have an identified natural support. Staff reported that contact with natural supports can range from weekly contact to at least monthly. Natural supports are contacted by phone, e-mail, or in person when members live with natural supports or when natural supports attend appointments with members. Staff reported documenting natural support contacts in the health record. The team offers a monthly support group facilitated by the Clinical Coordinator to natural supports to provide resources and education regarding member's psychiatric diagnoses. Four unique natural	• Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four (4) per month for each member with a support system.

			supports attended the most recent group per the group sign-in sheets provided. In the observed program meeting, there were 31 mentions of confirmed or planned contact with member's known supports. One member reported recent engagement between the team and their natural support that accompanied the member to one of their appointments. Of the 10 records reviewed, 70% had identified natural supports and four records had documented contact with natural supports. The average contact with natural supports was 1.10 contacts per month.	
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	Staff reported that 73% of members were identified as having co-occurring disorders. Of the members with co-occurring disorders, staff reported that up to 82% were currently engaged in individual substance use treatment ranging from monthly sessions to three times a week for 45 to 55-minute sessions. Per the member calendars provided, 61% of members with co-occurring disorders received individual substance treatment, with an average of 3.5 sessions per month, and approximately 40 average minutes per session resulting in an average of approximately 21 minutes per member with co-occurring disorders. Staff reported utilizing different stagewise approaches and curriculum based on the	• Continue efforts to increase the time spent in individual treatment sessions and increase the number of members engaged so that the average time is 24 minutes, or more, per week across the group of members with co-occurring disorders.

			member's current stage of change to individualize member's treatment, including the *SAMHSA Integrated Treatment for Co-Occurring Disorders* curriculum provided to reviewers.	
S8	Co-Occurring Disorders Treatment Groups	1 – 5 3	Staff reported that 25% of members with co-occurring disorders have attended a substance use treatment group in the past month. The team offers four groups facilitated by the Co-occurring Disorders Specialists. Three of the groups are offered in the clinic during the week and one group is held in the community on the weekend. Each group caters to members in different stages of recovery. Per the sign-in sheets provided for a recent month, 25% of members with co-occurring disorders were engaged in substance use treatment groups. Staff reported using stage-wise approaches and "integrated dual disorder treatment" (currently referred to as Integrated treatment for Co-Occurring Disorders) in group substance use treatment.	• On ACT teams, all staff participate in engaging members with co-occurring disorders to participate in treatment groups. Ideally, at least 50% of members diagnosed with co-occurring disorders attend at least one treatment group monthly.
S9	Co-Occurring Disorders Model	1 – 5 5	All staff reported encouraging members to minimize their substance use or mitigate risky substance use practices to promote incremental progress in their substance recovery over time rather than abstinence. Some staff also reported familiarity of stage-wise approaches, and catering interventions to member's current stage of change. Staff also reported utilizing motivational interviewing to engage members. Staff do not refer to outside peer-run substance use treatment groups (e.g., Alcoholics	Continue to provide all specialists with annual training, at a minimum, and ongoing mentoring in a co-occurring disorders treatment model, such as Integrated Treatment for Co-Occurring Disorders, in the principles of a stage-wise approach to interventions, and the EBPs of harm reduction and motivational interviewing.

			Anonymous), however, if members are interested in these groups, staff will accompany them. The team reported referring to detoxification facilities when necessary for members using alcohol or opioids. The Co-Occurring Disorders Specialists present case studies of members with co-occurring disorders on a weekly basis. The Co-Occurring Disorders Specialists review the member's diagnosis, their current stage of change, and appropriate interventions as a means to train the rest of the team in co-occurring disorders treatment and stage-wise approaches. Eight of the 10 records reviewed were of members identified with co-occurring disorders. All but one plan had current substance use disorder goals. All other plans had individualized substance use goals such as practicing reduction of use, reducing cravings, engaging in individualized or group substance use treatment, or building rapport with the Co-Occurring Disorders Specialists, or exploring community treatment groups with the support of ACT staff.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff reported that the team has at least three staff with lived or living psychiatric experience including certified peer staff that all share the same levels of responsibilities as other staff. Staff were aware of these staff sharing their stories of recovery with the rest of the team and members. Peers on staff also advocate from the peer perspective to the rest of the team.	

			Members were unaware of peers on the team.	
Total Score:		**118**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score
1. Small Caseload	1 - 5	5
2. Team Approach	1 - 5	3
3. Program Meeting	1 - 5	5
4. Practicing ACT Leader	1 - 5	4
5. Continuity of Staffing	1 - 5	5
6. Staff Capacity	1 - 5	5
7. Psychiatrist on Team	1 - 5	5
8. Nurse on Team	1 - 5	5
9. Co-Occurring Disorders 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. Explicit Admission Criteria	1 - 5	5
2. Intake Rate	1 - 5	5
3. Full Responsibility for Treatment Services	1 - 5	3
4. Responsibility for Crisis Services	1 - 5	5
5. Responsibility for Hospital Admissions	1 - 5	3

6. Responsibility for Hospital Discharge Planning	1 - 5	5
7. Time-unlimited Services	1 - 5	5
Nature of Services	Rating Range	Score
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	3
5. Frequency of Contact	1 - 5	2
6. Work with Support System	1 - 5	4
7. Individualized Co-Occurring Disorders Treatment	1 - 5	4
8. Co-occurring Disorders Treatment Groups	1 - 5	3
9. Co-occurring Disorders Model	1 - 5	5
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**4.21**	
Highest Possible Score	**5**	