ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with the 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 October 14 – 16, 2024, Fidelity Reviewers completed a review of the Southwest Network Saguaro 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.

Southwest Network provides services to children, adolescents, and adults. The agency operates three ACT teams in the Central Region of Arizona. This review focuses on the Saguaro ACT team. The individuals served through the agency are referred to as "*members*" or "*clients*", but for the purpose of this report, and for consistency across fidelity reports, the term "*member*" will be used.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to observe meetings and to interview staff and members.

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

- Remote observation of an ACT team program meeting on October 15, 2024.
- Individual videoconference interview with the Clinical Coordinator (CC).

- Individual videoconference interviews with the Co-Occurring Disorders Specialist, Housing, Employment, Peer Support, and Independent Living Specialists for the team.
- Individual phone interviews with two (2) members participating in ACT services with the team.
- Closeout discussion with the CC and representatives from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for 10 randomly selected members using the agency's electronic health records system. The sample included members from the following health plans: contractor with a Regional Behavioral Health Agreement and Division of Developmental Disabilities.
- Review of documents: *Mercy Care ACT Admission Criteria*; *Southwest Network Member Contact Guidelines*; *Southwest Network Lack of Contact Checklist;* checklist for referral to ACT; *Welcome to Assertive Community Treatment* handout; member calendars; Group Treatment for Substance Abuse A Stages-of-Change Therapy Manual (Velasquez et al., 2001) curriculum cover page; co-occurring disorders treatment group sign-in sheets; resumes and training records for the Employment, Rehabilitation, and Co-Occurring Disorders Specialist staff; and a copy of a CC productivity report from a recent 30-day period.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a 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 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 & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Program Meeting: All team staff, including the Psychiatrist, meet four (4) days a week to review all members. The team uses the meeting to focus on member needs and concerns, solve problems, and engage in person-centered planning.
- Practicing ACT Leader: The CC increased the delivery of in-person services to members since the last review, accounting for approximately 45% of the productivity level expected from other ACT staff.
- Program Size: The team is comprised of 10 full-time equivalent (FTE) staff, including the Psychiatrist, and is sufficiently sized to provide diversity and coverage to members.
- Work with Support System: Since the last review, the team increased engagement with members' natural support systems to at least twice monthly. Staff attempt regular contact with support during the natural course of service delivery to members.

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

- Community-Based Services: Increase the delivery of services to members in their communities; 80% or more of services occur in members' communities. Delivering services in the community offers opportunities for staff to directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting.

- Intensity of Services: Increase the duration of service delivery 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.
- Frequency of Services: Identify and resolve barriers to increasing contacts with members. Optimally, members receive an average of four (4) or more in-person contacts a week.
- Co-Occurring Groups: Ideally, 50% or more of applicable members participate in a co-occurring group. Continue to engage members with co-occurring disorders to participate in group substance use treatment, as appropriate, based on their stage of change.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, the team served 94 members with nine (9) full-time equivalent (FTE) direct service staff, excluding the psychiatric prescriber and administrative staff, resulting in a member-to-staff ratio of approximately 11:1. Positions on the team include the CC, Rehabilitation Specialist, Employment Specialist, Housing Specialist, Independent Living Specialist, Peer Support Specialist, Co-Occurring Disorders Specialist, and two Registered Nurses.	• If not done so already, prioritize filling vacant positions on the team to make certain a 10:1 member-to-staff ratio exists. Small caseload size ensures adequate intensity and individualization of services and minimizes the potential burden on staff.
H2	Team Approach	1 – 5 3	The team reports utilizing a geographic zone approach that rotates weekly to engage members. Staff provided varied reports regarding the percentage of members seen more than once over a two-week period; one staff reported 100% of members are seen and another staff reported seeing approximately 16% of members each week. Members reported seeing one to two staff each week. Contact is tracked during the program meeting, documented in the member record, and in member calendars. Staff are assigned caseloads of up to 12 members and are responsible for providing those members with one weekly contact, as well as completing administrative tasks, such as treatment plans and assessments.	• Eliminate caseload assignment. ACT teams are designed with high-needs members in mind. The entire caseload should be shared across ACT team staff. Diversity of staff interaction allows members access to unique perspectives and expertise of staff, as well as the potential to reduce burden of responsibility of member care on staff. • Ideally, 90% of ACT members have in-person contact with more than one staff in a two-week period. ACT staff are cross trained to work as a transdisciplinary team rather than individual case managers. Further, ACT team staff collaborate on assessments, treatment planning, and day-to-day interventions.

			Of 10 randomly selected member records reviewed for a month period, a median of 60% received in-person contact from more than one staff in a two-week period.	
H3	Program Meeting	1 – 5 5	Per interviews with staff, the team meets in person four times weekly and reviews all members on the roster; all staff, including the prescriber, are expected to attend on scheduled workdays. During the program meeting observed, the team discussed recent contact with members, member stages of change, housing needs, employment and inpatient treatment updates, outreach attempts, natural support contact, and planned future contact. Administrative staff announced member names from the roster, and the CC guided the meeting by providing staff with clinical direction relating to the prioritization of service delivery to address member needs.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimates providing direct in-person services to members 60% of the time. Reported activities include meeting members that are new to the team, hospital visits, and home visits. Staff reported team specialists are expected to deliver 20 hours of direct in-person services to members per week. A productivity report provided to reviewers for a recent 30-day period showed the CC provides direct services at approximately 45% of the productivity level expected of other ACT staff.	• Continue efforts to provide in-person services to members 50% or more of the expected productivity of other ACT staff. The CC and agency may consider identifying administrative functions not essential to the CC's time that could be performed by the program assistant or other team members.

			Of the 10 records reviewed, 70% showed the CC conducting home visits with members and occasionally the members' natural support. Records documented discussions on a variety of topics during home visits, such as employment, housing needs, living with grief, harm reduction, and individual and group co-occurring disorders treatment. *This item is dependent on the Provider productivity expectation.*	
H5	Continuity of Staffing	1 – 5 4	Based on the information provided, seven staff left the team, resulting in a turnover rate of 29% during the past two years. The positions with the highest turnover were the Rehabilitation and ACT Specialists.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports the therapeutic relationship between members and staff, and team cohesion. Sharing the entire caseload across the team promotes collaboration and unity as the team works together to provide member services.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the team operated at approximately 84% of full staffing capacity. There were a total of 23 vacant positions in the last 12 months. The Rehabilitation Specialist position was vacant for nine months, and the Housing Specialist position was vacant for six months.	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible with the goal of operating at 95%, or more, of full staffing annually. The timely filling of vacant positions also helps to reduce the potential burden on staff.
H7	Psychiatrist on Team	1 – 5 5	The team includes one Psychiatrist that serves the 94-member roster, working Tuesday through Friday for a total of 40 hours per week. Staff report the Psychiatrist provides services to members in person at the office and in the community. The Psychiatrist is also available to provide services via telehealth when appropriate. Members reported seeing the	

			Psychiatrist once every four weeks in person at the clinic. According to staff, the Psychiatrist is accessible via messaging platforms, in person at the clinic, by phone, and email. Staff reported the Psychiatrist is also accessible after hours; staff contact the CC, and the CC contacts the Psychiatrist, when necessary. Most member records reviewed showed the Psychiatrist meeting with members at the clinic once every 30 days. One record showed a member seeing the Psychiatrist two times in a 30-day period; documentation from both appointments showed the inclusion of the member's natural support.	
H8	Nurse on Team	1 – 5 5	The team has two Registered Nurses that work exclusively with the ACT members, 10 hours a day, four days a week. Staff reported the Nurses assist with medical issues, coordinate with outside providers, administer injections (both in the clinic and community), take vitals, have assigned caseloads, provide members with case management, and conduct home visits. Nurses are accessible via messaging platforms, in person at the clinic, by phone, and by email. Nurses do not participate in the on-call rotation for after-hours crisis response but are accessible after hours via email. Of the 10 records reviewed, eight had documentation of the Nurses delivering services to members. Of these, 25% showed one of the Nurses delivering services to members in the community.	

H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	The team is staffed with one Co-Occurring Disorders Specialist (CODS) that has been on the team for over one year. Training records provided showed the CODS had over one hour of training related to substance use treatment in the past two years. The CODS receives regular clinical supervision from a qualified professional relating to the provision of services to individuals with co-occurring disorders.	• ACT teams are staffed with two Co-Occurring Disorders Specialists for a roster of 100 members, each with one year or more of training/experience providing substance use treatment services. • Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. On ACT teams, CODS can cross-train other staff, provide guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model used by the team.
H10	Vocational Specialist on Team	1 – 5 4	The team has one Employment Specialist (ES) and one Rehabilitation Specialist (RS); both specialists have over one year of experience assisting members in finding and retaining employment in integrated settings. At the time of the review, the ES had been on the team for over one year and the RS had been on the team for one month. A review of training records for the specialists over the past two years shows the ES received at least seven hours of training focused on supporting individuals with serious mental illness in obtaining and retaining employment; there was no evidence of recent trainings completed by the RS.	• Provide ongoing training, guidance, and supervision to Vocational Specialist staff related to support and best practices that aid members to obtain competitive positions in integrated work settings. Consider focusing training on techniques to engage members to consider employment; job development strategies; the importance of supporting in-person employer contact soon after members express an employment goal; and the provision of follow-along supports to employed members.
H11	Program Size	1 – 5	At the time of the review, the team was comprised of 10 FTE staff, including the	

		5	Psychiatrist. The team is sufficiently sized to provide diversity and coverage to members. Current vacant positions include one Co-Occurring Disorders Specialist and one ACT Specialist.	
O1	Explicit Admission Criteria	1 – 5 5	The team follows the *Mercy Care ACT Admission Criteria* to screen new referrals, and a copy was provided to reviewers. Staff reported the team receives referrals internally from supportive and connective teams and externally from entities such as jails, hospitals, and the contractor with a Regional Behavioral Health Agreement. The CC conducts the initial screening and will staff with the Psychiatrist or agency director if necessary. Upon receiving a referral, the CC schedules a meeting to review admission criteria with the potential member to provide information about ACT services. Next, the Psychiatrist reviews the potential member's history and meets with the CC to discuss. The Psychiatrist then coordinates with the referring provider. Staff reported the Psychiatrist and potential member have the final say regarding admission to the team; staff do not experience external pressure to admit members. The team roster includes three members with Intellectual Developmental Disabilities (IDD) that are living in IDD housing; staff coordinate care for these members by participating in Adult Recovery Team meetings every three months.	
O2	Intake Rate	1 – 5	Per the data provided, the team maintains an appropriate rate of admission. During the six months prior to the review, April and July had	• Consider staffing capacity when admitting new members to ensure team ability to provide them with intensive services to meet

		5	the highest intake rate, with four new members added to the team. In April, the team had three vacant positions; the team was adequately staffed during the remaining five months.	their needs and to alleviate the potential burden on staff.
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services and medication management, housing support, substance use treatment, and employment/rehabilitative services. Per interviews, the team does not have staff qualified to provide counseling or psychotherapy services; members in need of counseling services are referred to outside providers. Staff reported up to three members were receiving counseling off the team at the time of the review.	• Ensure future staffing includes a person with qualifications to provide counseling/psychotherapy to members. Counseling/psychotherapy is available to members on ACT teams and provided by ACT staff. This staff will also act as a generalist within the team.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24/7 crisis services to members, with the on-call phone rotating weekly among specialists and the CC providing backup support. Upon onboarding the team, members are provided with a *Welcome to Assertive Community Treatment* handout that includes the team on-call phone number, hours of operation, and the names, titles, and phone numbers of team staff. When a distressed member calls the on-call phone, staff assess the situation, attempt de-escalation, and coordinate with the CC before meeting members in the community. Upon arrival, staff assess the member further, relay information to the CC, and the CC may consult with the Psychiatrist. Depending on staff assessment and clinical direction, members may	

			be scheduled for an emergency appointment with the Psychiatrist the following day, or staff will transport the member to a hospital for further assessment. Interviewed members were aware of the on-call number but reported never needing to utilize it. Staff reported that members will occasionally call other crisis lines or resources rather than the ACT team, and those responders will often direct members back to the team. Staff reported encouraging and reminding members to utilize the team on-call line.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff reported active involvement in member psychiatric hospital admissions. When a member expresses the need for inpatient stabilization, staff offer an emergency appointment with the Psychiatrist. Once it is determined hospitalization is required, the most recent Psychiatrist note is printed, and staff transport the member to the hospital. Staff stay with the member through intake and provide the inpatient team with necessary documentation upon admittance. Staff rotate the responsibility to visit the member while inpatient; the Psychiatrist completes coordination with the inpatient provider within 72 hours, and team Nurses are available to coordinate member care with the inpatient team. Based on the data provided and reviewed with staff of the 10 most recent psychiatric hospitalizations that occurred over a three-month time frame, the team was involved in 80%	• 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. • 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 provide aid during admission, especially for members with a history of seeking hospitalization without team support.

			of admissions. Of the admissions in which staff were not involved, members self-admitted, and the team was notified afterward.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported discharge planning with the inpatient team and member, and occasionally the member's natural support, occurs prior to discharge. When a discharge date has been provided, staff coordinate transportation and are available to transport the member directly or will be present at the discharge when the member's natural support provides transportation. Staff ensure the environment members are discharged to is safe and that they have all prescribed medications. Reviewers were provided with the *Southwest Network Member Contact Guidelines*. Per a review of this document, records, and staff interviews, staff follow up with members in person for five consecutive days after discharging from the hospital; five-day follow-up includes an appointment with the team Psychiatrist within 72 hours of discharging. Per a review of data with staff relating to the last 10 psychiatric hospital discharges that occurred over a three-month time period, the team was directly involved in 100% of discharges.	
O7	Time-unlimited Services	1 – 5 5	Data provided indicated the team did not graduate any members in the past 12 months. Staff anticipate two members will graduate in the next 12 months.	
S1	Community-based Services	1 – 5	Staff interviewed reported 60 - 85% of in-person contact with members occurs in the community. Of the two members interviewed, one reported	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members'

		2	seeing staff in the community once a week; the second member reported seeing staff in the community once every other week. Results of 10 randomly selected member records reviewed show staff provided services a median of 33% of the time in the community. Records indicated members were seen in the office an average of 3.1 times during the 30-day period.	communities where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting. • Ensure all staff engage with members of the community at a similar level to what was reported by staff interviewed.
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had three members leave the program in the past year. The team retained 97% of the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reported the team makes at least two attempts weekly, over 8 -12 weeks, to reengage members that have been difficult to contact; staff use motivational techniques when outreaching members. One outreach attempt is conducted by phone, and the second attempt is conducted in the community (e.g., home visits and checking areas members are known to frequent). Per interviews, formal implementation of the outreach protocol begins after a member misses three consecutive appointments with the Psychiatrist; however, the team attempts reengagement by phone or home visit after the member's first missed appointment. After the second missed appointment, staff contact law enforcement to conduct a wellness check and begin reaching out to community agencies, such as hospitals, jails, and the medical examiner.	• Develop an Assertive Engagement policy for the ACT team. In the EBP of ACT, engagement processes are clear. A minimum contact timeline and outlined team activities would help to ensure staff are consistent in their efforts to engage members. • When members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Consider peer review of documentation to ensure efforts are accurately included in member records. • Ensure staff are familiar with the outreach expectations outlined in the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual.*

			According to the *Southwest Network Lack of Contact Checklist* provided, outreach occurs for a minimum of eight weeks. During weeks one and two, three outreach attempts are required, one of which occurs in the community. Two outreach attempts are required for weeks three through eight, and one of the two attempts needs to occur in the community. Of the records reviewed, 40% lacked documented contact for 9 or more days. Of these records, one record showed no documented community outreach; medical examiner and jail website checks were the only documented outreach attempts during a 30-day period.	
S4	Intensity of Services	1 – 5 2	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 is 38 minutes per week. The highest weekly average for in-person services was 75.75 minutes, and the lowest was zero minutes. Phone contact was evidenced in 90% of records reviewed. Members received contact by phone a median of two times per month, and the median duration of each call was 1.88 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. Ensure services are accurately documented. • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. Documented service time is significantly higher for some members than for others.
S5	Frequency of Contact	1 – 5	Of the 10 records randomly sampled, staff provided a median frequency of 1.63 weekly in-person contacts to members. The record with	• Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week. Work with staff to

		2	the highest frequency was 2.5 contacts, and two records showed zero weekly in-person contacts.	identify and resolve barriers to increasing the frequency of contact. • 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.
S6	Work with Support System	1 – 5 4	Data provided identified 34 (36%) members with natural supports. The team documents contact with natural supports within the member record. Staff reported weekly contact with member support occurs during home visits or by phone. Regarding staff contact with natural supports over the past month, one staff estimated contacting approximately 25 supports one to two times a week, and another staff estimated attempting to contact all 34 natural supports once weekly. Of the two members interviewed, one reported staff does not have contact with their natural supports. The other member reported staff offered to contact their supports upon admission to the team; the member introduced staff to their family after joining the team, but contact has not occurred since.	• Assist members in developing a natural, community-based support system. Active participation with peer run programs is a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact. • 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.

			During the program meeting observed, natural support contact was discussed for at least 30 members; at least 12 instances of direct contact with natural supports was reported. Records reviewed showed an average of 2.20 contacts with members' natural supports during a 30-day period. The record with the highest frequency of natural support contact showed staff interacting with the member's natural supports 14 times.	
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	Based on the data provided and discussed with staff, there are 35 (37%) members on the roster with co-occurring disorders. Staff reported the CODS attempts to engage all 35 members in structured individualized substance use treatment, and 15 to 18 members are currently participating in individual sessions. Data provided indicated six unique members received individualized substance use treatment one or two times in the past 30 days, for an average of 14 minutes per session. Per review of member calendars for a month period, four unique members appear to be scheduled for weekly, hour-long, individual sessions with the CODS; per interviews, member calendars are not always updated when the member doesn't show for scheduled appointments. During the observed program meeting, it was reported that 16 members with co-occurring disorders received, or were scheduled to receive, individual substance use treatment with the CODS; engagement attempts were discussed for an additional 16 members.	• Work to provide an average of 24 minutes, or more, per week of structured individualized substance use treatment services for all members with co-occurring disorders. • Monitor member engagement and participation in individual substance use treatment. • Document the offering of services and the delivery of individual treatment to members with co-occurring disorders. Explore training on strategies to engage members in substance use treatment. • Evaluate if CODS participation in other duties, such as medication observation, limits the ability to engage or provide individual substance use treatment. Consider shifting those duties to other staff when indicated.

			Of the 10 records reviewed, four had co-occurring disorders. Among the four, one record showed evidence of an individual treatment session occurring during the 30-day period.	
S8	Co-Occurring Disorders Treatment Groups	1 – 5 2	Staff interviews revealed the team provides one weekly co-occurring disorders treatment group, led by the CODS. Staff reported using curriculum based on the transtheoretical model (stages of change) of substance use treatment. Records reviewed indicate worksheets related to stages of change and the effects of substance use on the brain were used during group treatment. Additionally, harm reduction strategies and coping skills were discussed; members shared their stories of recovery and identified their current stage of change. A review of sign-in sheets from the month prior to the review showed four unique members with co-occurring disorders (11%) participated in the group.	• Optimally, 50% or more of members with a substance use disorder attend at least one co-occurring disorders treatment group each month. On ACT teams, all staff engage members with co-occurring disorders to participate in treatment groups, based on their stage of change, with content reflecting stage-wise treatment approaches. • Co-occurring disorder treatment groups work best when based in an evidence-based practice (EBP) treatment model. Consider structuring groups around proven curriculum for this population for optimal impact. • Staff may benefit from training in strategies to engage members in group substance use treatment.
S9	Co-Occurring Disorders Model	1 – 5 4	Staff interviews reflected the team's knowledge and utilization of harm reduction strategies, motivational interviewing techniques, and a person-centered approach when supporting members with co-occurring disorders. Staff used non-judgmental language and reported some familiarity with the principles of a stage-wise treatment approach. Staff do not refer members to peer-run meetings but do refer to detoxification programs when members are using substances, such as alcohol and fentanyl;	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as *Integrated Co-Occurring Disorders Treatment*, in the principles of a *stage-wise approach* to interventions, the EBP of *harm reduction,* and *motivational interviewing.*

			the Psychiatrist determines when detoxification programs are medically necessary for members. During the program meeting observed, staff used recovery-focused language while discussing interventions for most (91%) of the members with co-occurring disorders. Among the four member records reviewed for individuals identified with co-occurring disorders, three included service plans with substance use treatment goals and interventions that identified how the team would support the member's progress to their goals (e.g., will engage in weekly individual substance use treatment or will attend substance use groups). Of the three service plans, two included goals that were written in traditional clinical language (e.g., remain substance-free or abstain from substances).	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team includes at least one staff with personal lived or living psychiatric experience and, when appropriate, shares their recovery journey with members. Of the members interviewed, 50% were aware of peers on the team. One member reported thinking of all staff as peers and indicated staff have not shared personal recovery stories. Another member reported the peer on staff is empathic to member issues and needs, which is valuable to the member.	
Total Score:		**113**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	4
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Co-Occurring Disorders Specialist on Team	1-5	3
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	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	4
7. Individualized Co-Occurring Disorders Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.04**	
Highest Possible Score	**5**	