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 January 6 – 8, 2025, Fidelity Reviewers completed a review of the Community Bridges Incorporated Forensic Assertive Community Treatment Two (FACT 2) team. This review is intended to provide specific feedback on 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.

Community Bridges, Inc. operates multiple locations across Arizona, offering services such as supportive housing, crisis stabilization, Assertive Community Treatment (ACT), and integrated healthcare. In the Central Region of Arizona, the organization manages three ACT teams and two FACT teams. The individuals served through the agency are referred to as *clients* and *members* 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 the FACT team program meeting on January 7, 2025.

- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with one Co-Occurring Disorders Specialist and two Vocational Specialists.
- Individual phone interviews with four members participating in FACT services with the team.
- Closeout discussion with the Director of Serious Mental Illness (SMI) Services, SMI Service Manager, F/ACT SMI Administrator, and a representative from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for ten 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 Other (Medicare, private, other source of coverage).
- Review of documents: *Mercy Care FACT Admission Criteria,* copy of cover page of material utilized; co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and Co-Occurring Disorders Specialist staff, and engagement protocol.

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:

- The recent onboarding of staff brought the team to sufficient size to provide coverage to the 69 members assigned to the team. The team has an appropriate member-to-staff ratio of 9:1.
- The FACT team has a clearly defined target population with whom they work; all staff are trained to conduct screenings of referrals and reported no outside pressure to admit members that do not meet criteria.
- The team is available to members to provide crisis support by phone and in the community after business hours and weekends.
- The team was involved in 100% of psychiatric hospital discharges.

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

- Fill vacant positions with qualified staff as soon as possible with the goal of operating at 95%. The team operated at 57% staffing capacity and experienced 41% staff turnover in the past two years.
- Increase the frequency of contact delivered to members. FACT staff should see every member on average four times a week. Higher frequency of contact correlates to improved outcomes for FACT members.
- Increase the duration of service delivery to members. FACT 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 their functioning in the community.

- Few members with a substance use disorder attend the co-occurring disorders treatment group provided by the team. Increase efforts to engage members with a co-occurring disorder 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 5	The FACT team serves 69 members with eight direct service staff, excluding the Psychiatric Mental Health Nurse Practitioner and Program Assistant. The team has a member-to-staff ratio of 9:1. The team includes: a Clinical Coordinator (CC), Rehabilitation Specialist, Employment Specialist, Registered Nurse, ACT Specialist, Housing Specialist, and two Co-Occurring Disorders Specialists (CODS).	
H2	Team Approach	1 – 5 2	Staff reported that 65% of members see more than one staff each week. Staff utilize a weekly zone rotation to support members in meeting with diverse staff. Staff reported experiencing barriers to adherence to a zone approach due to vacant staff positions. When emergent issues arise and plans change, staff will adjust schedules to meet the members with urgent needs. The team tracks contact with members during the morning meeting and through progress note documentation. Members interviewed reported contact with one or sometimes two different staff each week. Per review of ten randomly selected member records, for a two-week period, 20% of members received in-person contact from more than one staff.	• Ideally, 90% of FACT members have in-person contact with more than one staff in a two-week period. Consider confirming attempts and successful contacts are documented in member records. • Increase in-person contact of diverse staff with members. All 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 unique perspectives and expertise of staff. Because of the number of vacant positions historically, it may be especially important for this team to follow a team approach as it likely

				would reduce the burden of responsibility of care on staff.
H3	Program Meeting	1 - 5 5	Staff reported meeting five days each week for member treatment planning. Most staff, including the Psychiatric Mental Health Nurse Practitioner, work four ten-hour days. Staff attend program meetings on scheduled workdays. Staff work staggered schedules to ensure weekend and holiday availability to assist members. During the program meeting observed, all scheduled staff were in attendance. The team briefly reviewed each member on the roster, discussing recent interactions, outreach efforts, upcoming appointments, contact with members' natural supports, legal and probationary obligations, hospitalizations and discharge planning, incarceration status, and members current stages of change.	
H4	Practicing ACT Leader	1 - 5 2	The CC joined the team in January 2024. The CC estimated delivering direct in-person services to members 45% of the time expected of other FACT specialists. The CC reported providing case management, a weekly skills training group, crisis intervention, and community outreach. Two of the records reviewed evidenced the CC provided: hospital discharge planning, home visits, and community outreach and reengagement. One additional record showed the CC providing services via- videoconference.	• Continue efforts to provide in-person services to members. Optimally, (Under ideal circumstances), the FACT CC delivers direct services to members accounting for at least 50% of the expected productivity of other FACT staff. (and be documented in member records.)

			Based on a review of the productivity report for a four-week period, the CC provided direct services for approximately 5% of the time. *The fidelity tool does not accommodate delivery of telehealth services.* *This item is dependent on the Provider productivity expectation.*	
H5	Continuity of Staffing	1 - 5 2	Based on information provided, and reviewed with staff, the team experienced an annual turnover rate of 41% during the past two years. Positions with the highest turnover frequency were the CC, Independent Living Specialist, Housing Specialist, CODS, and Peer Support Specialist. These positions each had at least two staff leaving the team.	• If not done so already, attempt to identify factors that contributed to staff turnover or that support retention. Ideally, turnover should be no greater than 20% during a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their supports, as well as reducing the potential burden on staff.
H6	Staff Capacity	1 - 5 2	In the past 12 months, the team operated at approximately 57% of full staffing capacity, with 62 months of vacant positions. Current unfilled positions included a Nurse, Peer Support Specialist, and an Independent Living Specialist. The Nurse and Independent Living Specialist positions have been vacant for 12 months. The CODS and Housing Specialist roles were 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 which can directly impact turnover. • Support specialty staff to work in their area of interest and expertise with members. Research shows staff remain in positions longer when supported in their

				roles by being provided supervision and training in their specialty practice.
H7	Psychiatrist on Team	1 - 5 5	The team has one Psychiatric Mental Health Nurse Practitioner (Prescriber). Staff reported the Prescriber meets members in office, in the community and via videoconference. The Prescriber dedicates one day a week to meeting members in the community and members incarcerated are seen by videoconference. The Prescriber serves as the medical director of the team and plays a central role in guiding treatment plans, ensuring medication stabilization and management, coordinating with other providers, and facilitating the integration of mental and physical healthcare. Records showed one member receiving a videoconference appointment.	
H8	Nurse on Team	1 - 5 4	The team had one dedicated Nurse recently join the team in December 2024. Staff reported, prior to the onboarding of the Nurse, services were provided by an agency nurse. The role of the Nurse includes office and community-based services of administering injections, providing health and medication education, coordinating care with outside facilities and hospitals, and attending specialty appointments with members. Five of the records evidenced members received Nurse services. Two Records evidenced services were provided in the office or in the community.	• Continue efforts to recruit and retain Nurses to ensure consistency of coverage for clinic-based services and community-based services. Having two full-time nurses is a critical ingredient of a successful FACT program • When allocating staff partial assignment to a FACT team, ensure those staff attend a minimum of two program meetings a week to allow a transfer of knowledge relating to member care.

			Five records evidenced non-FACT nurse providing coverage.	
H9	Co-Occurring Disorders Specialist on Team	1 - 5 3	The team has two CODS to provide substance use services to 49 members. One CODS has been with the team since January 2023. The records provided show the completion of three trainings relating to co-occurring disorders. The second CODS recently joined the team in January 2024. Resume and training records were not received for review. Staff report the CODS receive weekly in-person individual supervision from a Licensed Professional Counselor.	• Provide eight (8) hours of annual training to CODSs in co-occurring disorders treatment best practices, such as appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. On FACT teams, CODS can cross-train other staff, and provide guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model used by the team. • Continue to provide CODS with supervision, 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 FACT staff.
H10	Vocational Specialist on Team	1 - 5 3	The team has two Vocational Specialist staff. The Employment Specialist has been with the team since September 2024. The Rehabilitation Specialist has been with the team since April 2024. Training records and resumes received did not indicate prior experience or trainings relating to helping members find and retain competitive employment in integrated work settings for either specialist.	• 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, the provision of follow-along supports to employed members, and training in helping members find and retain competitive employment in integrated settings. • Supervision by qualified staff should be provided to support skill development during this first year in the role when there is no prior experience.
H11	Program Size	1 - 5 4	At the time of the review, the team was composed of 9 staff, including the Prescriber. The team is of sufficient size to provide the necessary staffing diversity and coverage with three vacant positions on the team. *This item does not adjust for the size of the client/member roster.*	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, with a minimum of 10 direct service staff, allows the team to consistently provide diverse coverage; helps to prevent potential staff burn-out; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member.
O1	Explicit Admission Criteria	1 - 5 5	The team follows the *Mercy Care FACT Admission Criteria* to evaluate potential admissions, seeking individuals that are assessed as having increased risk of recidivism. Referrals typically come from Maricopa County Probation, Maricopa County Correctional Health, and Mercy Maricopa Court Services Department. The CC primarily conducts the screenings of referrals, and all team specialists are trained in the screening process for new admissions. When new referrals meet criteria, staff discuss with the Prescriber, for	

			approval. Members and member's guardians make the final decision to enroll.	
O2	Intake Rate	1 - 5 5	Per data provided, and reviewed with staff, the team had an intake rate of four new members over the past six months. The month with the highest admission was August 2024 with two new members added to the roster.	
O3	Full Responsibility for Treatment Services	1 - 5 3	In addition to case management, the team provides psychiatric medication management services, employment and rehabilitative services. Fourteen members (20%) are in housing in which services provided by the FACT team are duplicated. Staff reported providing these members with weekly home visits, case management and psychiatric medication management services. The team holds monthly meetings with the residential service providers to reassess ongoing needs and transition planning. When members require supportive housing services for longer than 30 days, the members' level of care is reevaluated and transferred from FACT to a supportive level of care team. The team does not include a licensed professional to provide counseling/ psychotherapy. Three members that are mandated by the legal system to engage in counseling have been referred to an outside agency. Two additional members receive counseling services through their residential	*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.* • 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 where all housing support and case management responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all services and support from the team. • Continue to educate other agencies or systems (e.g., criminal justice system representatives) on the scope of ACT services, such as the availability of substance use treatment.

			treatment facility. Staff were unclear how coordination with outside providers would occur. Over 10% of the members receive substance use treatment services from providers other than the FACT team. Staff estimated 7 -10 members receive inpatient substance use treatment services and two members receive substance use counseling off the team.	• Consider options to provide court ordered services and treatment through the ACT team. Ideally, specialty services such as substance use treatment and counseling/psychotherapy are provided by highly skilled clinicians and/or under qualified clinical oversight to satisfy the expectations of system partners in the justice system. Specialists should be encouraged and supported in their professional development to achieve this outcome when appropriate.
O4	Responsibility for Crisis Services	1 - 5 5	The team provides 24-hour coverage directly to members of the team. Team specialists rotate on-call phone coverage responsibility every one to two days. Members are provided with a team contact list that includes contact information for on-call crisis phone number. When members contact the on-call line, staff conduct a risk assessment to determine appropriate interventions. Staff will mobilize into the community in case of psychiatric emergency or if the member cannot be stabilized telephonically. When emergency services (911) are needed, staff meet emergency workers in the community to assist for coordination of care. When hospitalization is required, staff will coordinate admission and transportation. Fifty percent of the members interviewed were aware of the team availability for crisis support.	

O5	Responsibility for Hospital Admissions	1 - 5 3	Staff reported being directly involved in member hospital admissions. When a member is experiencing an increase in symptoms, or crisis, the team will meet with the member in the community to complete a risk assessment. Members are encouraged to meet with the Prescriber when hospitalization is being considered. When it is decided that inpatient care is necessary, FACT staff will transport the member and assist with the admission process, remaining with the member until admitted. When emergency services are involved, staff will advocate on behalf of the member and staff will follow or meet at the psychiatric unit for admission. Based on the data reviewed with staff, the FACT team was involved in 40% of psychiatric hospital admissions which occurred over a four-month period. For the admissions without involvement, individuals self-admitted without seeking team support.	• FACT 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. • Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build a rapport with natural support. • Educate members and their support systems about team availability to support members in their communities or to assist with hospital admissions.
O6	Responsibility for Hospital Discharge Planning	1 - 5 5	Staff stated discharge planning begins upon notice of admission. The team schedules staffings with the inpatient team typically 24 hours after admission and weekly thereafter. The Prescriber will consult with the hospital physician and staff visit members every 72 hours. Staff will coordinate discharge planning alongside members, including natural supports or guardians. Staff will meet members at the hospital for a warm handoff when discharging	

			from inpatient care. The team provides home visits as part of a five-day follow-up routine. Members are scheduled to meet with the Prescriber within 72 hours of discharge and staff will attempt in-person encounters for five days following the discharge for four weeks. Based on data provided and reviewed with staff, the FACT team was involved in 100% of psychiatric hospital discharges which occurred over a four-month period.	
O7	Time-unlimited Services	1 - 5 5	Data provided shows that the team graduated two members in the past 12 months resulting in a graduation rate of 2%. Staff interviewed stated that less than 5% of members are on track for graduating in the next year.	
S1	Community-based Services	1 - 5 1	Staff reported that 80% of in-person contacts with members occur in the community. Ten randomly selected member records showed a median of 0% of services were community-based. Records showed three members received community services. Services were provided in member homes and in hospital settings. Two additional records showed community services provided by non-team staff. Five records lacked documentation of any community encounters by the team. *Staff must attend a minimum of two program meetings a week to receive credit in this item and*	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities, where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting. • When allocating staff partial assignment to the FACT team, ensure those staff attend a minimum of two program meetings a week to allow a transfer of knowledge relating to member care.

			be considered part of the team roster, even if only partially assigned.	
S2	No Drop-out Policy	1 - 5 4	According to data provided and reviewed with staff, the team had six members drop out of the program in the past year. The team retained 93% of the total number of members served in the past 12 months. Two members could not be located, four members were transferred to a higher level of care or incarcerated. Staff reported that when members move off the team, members are able to rejoin the team without a new referral if within one year.	• FACT teams ideally retain 95% of the entire caseload yearly. Work to retain membership in FACT. Several factors can impact this number positively including a clear admission policy, consistency in staffing, natural support involvement, assertive engagement practices, and taking a recovery perspective and client-centered approach with member care.
S3	Assertive Engagement Mechanisms	1 - 5 3	Staff reported attempting to make contact with members four times per week. When members are in jail custody, staff schedule weekly video-conference meetings. Staff state that the FACT team attempts to build therapeutic alliance by being neutral and separate from probation or parole services. Staff practice active listening and offer supportive services like going to the bank, offering resources like food boxes, or assistance applying for resources like hotel and housing vouchers. When members miss appointments or cannot be located, staff will search in the community, call natural supports, contact probation, check jails and the medical examiner's office, and file amendments to court order services. During the observed program meeting, three members were identified by staff as needing continued outreach efforts for reengagement.	• When members are not seen at the frequency indicative of FACT services, consider starting outreach efforts immediately after an identified lapse in contact. Discuss and track these efforts during the program meeting. • Monitor documented outreach and contacts with members. It may be useful to assign one staff to verify documentation in member records (peer review) during the program meeting to confirm recent contacts or outreach efforts are entered. This may enable the team to proactively assign alternating staff to outreach in the event of lapses.

			One record reviewed evidenced outreach attempts through community outreach, jail inmate search, and checking the medical examiner's office. One additional record indicated that engagement attempts were made 15 days between each outreach attempt. Six of the member records reviewed did not show any documented contact notes or outreach attempts.	
S4	Intensity of Services	1 - 5 1	Per a review of ten randomly selected member records, during a month period before the fidelity review, the median amount of time the team spent in-person with members per week was zero minutes. The highest duration was 36.5 minutes, and six records showed zero minutes of in-person contact. *The fidelity tool does not accommodate delivery of telehealth services.*	• FACT 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. • Ensure the team is assisting members in working on recovery goals as identified by using a client-centered approach. 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 1	Per review of ten randomly selected member records, during a month period before the fidelity review, the median in-person contact with members was zero times per week. The highest frequency was 1.25 and six records had zero in-person contacts documented.	• Increase the frequency of contact with members, preferably averaging four (4) or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. • Ensure staff are trained and supported in using appropriate documentation

				standards to ensure that services delivered are appropriately reflected in medical records in a timely manner.
S6	Work with Support System	1 - 5 1	Staff report that 30 to 45 members (65%) have natural supports, such as family or community connections. Staff reported engaging with 90% of these supports and tailor involvement to each member's preferences by obtaining signed consent. Member calendars track natural supports' contact information and interactions are reportedly documented in their records. Staff stated prioritizing the engagement of natural supports during hospitalizations and re-engagement efforts, ensuring personalized and comprehensive care. Approximately, 15 members live with natural supports, and staff conduct weekly in-person engagements and maintain regular phone communication In the program meeting observed, staff discussed recent contact with eight natural supports. Staff coordinated with natural supports about jail release, coordinated member appointments, outreach after no-show appointments, contact during home visits, well checks, and housing coordination. Records reviewed showed an average of zero documented contacts with natural supports during a month period before the fidelity review.	• 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. • Increase contacts with natural supports to an average of four (4) per month for each member with a support system. As much as possible, contact natural supports during the natural course of delivery of services provided to members. • The team may want to consider monitoring documentation of contacts with Natural Supports into member clinical records. Some teams review and track these contacts during the program meeting.

			Members interviewed reported staff do not have contact with their natural supports.	
S7	Individualized Co-Occurring Disorders Treatment	1 - 5 3	Per interviews and data provided, 49 members were identified with co-occurring disorders. Staff reported that 100% of these members are receiving in-person structured individual co-occurring disorder treatment from a CODS. Material described as being used to provide treatment focus on integrating co-occurring disorders. Staff reported members receive weekly individualized services and the average session length is 30 – 60 minutes. Some members receive brief encounters based on readiness and current stage of change. Monitoring of individual substance use treatment is discussed in program meetings and documented in the member record. Five of the records reviewed were identified as having co-occurring disorders. Zero records showed evidence of engagement relating to individualized co-occurring disorders treatment.	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders. • Monitor member engagement and participation in individual substance use treatment service delivery by the FACT team. • 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 • Ensure all services delivered are documented in member records
S8	Co-Occurring Disorders Treatment Groups	1 - 5 1	The FACT team provides one group weekly at the clinic for members with co-occurring disorders diagnosis. At the time of the review, staff reported that approximately six members attended groups. Group sign-in sheets submitted to reviewers show two of the 49 members identified as having a co-occurring disorder attended at least one group in a month period reviewed.	• Optimally, 50% or more of members with a substance use disorder attend at least one co-occurring disorders treatment group each month. On FACT 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.

				• Engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment.
S9	Co-Occurring Disorders Model	1 - 5 3	Staff reported using a stage-wise treatment approach, which allows for interventions to be adjusted based on the member's current stage of recovery. To support best practices in working with individuals with co-occurring disorders, staff participate in weekly - monthly training sessions. Training is completed in person or through virtual platforms. Rather than promoting abstinence, staff employ harm reduction strategies to enhance safety and improve overall health outcomes, supporting members in their unique recovery journey. During the observed program meeting, staff identified members' stage of change, motivation to join co-occurring disorders groups, and interest levels for engaging with the CODSs. Records reviewed identified five members as having a co-occurring disorder. Two treatment plans specifically addressed substance use reduction or *abstinence*, though residential treatment appears to be the primary intervention. One treatment plan identified the PSS and drug screening as the intervention for identifying triggers to use and development of coping strategies, rather than the staff specializing in substance use treatment. Three of the five records lacked progress notes, or	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.* • Ensure treatment plans are written from the member's point of view, recovery focused, and outline steps the team will take to address substance use while supporting the member in recovery. Support members to identify a reduction of use goal when a desire for abstinence is expressed. • With staff turnover, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Identifying a co-occurring disorders treatment model that the team adheres to can promote continuity in the approach that FACT specialists use when supporting members in recovery.

			documented engagement attempts for at least 30 days.	
S10	Role of Consumers on Treatment Team	1 – 5 5	At the time of the review, the Peer Support Specialist position was vacant. However, the team is staffed with one or more individuals with personal lived experience of psychiatric recovery. Staff share stories of personal lived psychiatric experiences with members when appropriate and provide staff with a peer perspective. Members interviewed reported being aware of staff sharing personal lived experiences. One members stated that shared stories are helpful in promoting hope and inspiration, stating, "*If staff can do it, I can too*."	
Total Score:		**91**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	2
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	2
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	4
9. Co-Occurring Disorders Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	4
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	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 (1-5)
1. Community-Based Services	1-5	1
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	1
5. Frequency of Contact	1-5	1
6. Work with Support System	1-5	1
7. Individualized Co-Occurring Disorders Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.25**	
Highest Possible Score	**5**	