ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

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Introduction

The 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 13 – 15, 2025, Fidelity Specialists completed a review of the **Copa Health - Gateway** ACT 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 Maricopa County.

Copa Health provides integrated behavioral health and community-based services to adults with serious mental illness and co-occurring disorders. The agency operates multiple Integrated Care Clinics offering outpatient behavioral health, primary care, pharmacy, employment support, day programs for adults with disabilities, and residential services. The individuals served through the program are referred to as *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:

- Remote observation of an ACT team program meeting on October 14, 2025.
- Group videoconference interview with the newly assigned Clinical Coordinator (CC) and ACT Support Liaison.

- Individual videoconference interviews with Co-Occurring Disorders, Rehabilitation, Independent Living, and Peer Support Specialists for the team.
- Individual phone interviews with members participating in services with the ACT team. Three (3) of the five members whose information was provided were successfully contacted.
- Closeout discussion with the CC, ACT Support Liaison, ACT Program Director, and representatives from the Arizona Health Care Cost Containment System and the contractor with a Regional Behavioral Health Agreement (RBHA).
- 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: RBHA, and Other (Medicare, private, or other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; member calendars; copies of cover pages of substance use disorder treatment materials utilized; co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and Co-Occurring Disorders Specialist staff; a productivity report for the CC from a recent 30-day period; team brochure and contact sheet; and *Eight Week SMI Outreach Workflow*.

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. The scale determines 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 and Key Recommendations

The agency demonstrated strengths in the following program areas:

- Nurse on Team: The team is sufficiently staffed with two full-time equivalent Registered Nurses to provide support to members.
- Intake Rate: The team has an appropriate intake rate of no more than four intakes per month in the past 6 months.
- Community-Based Services: The team showed significant improvement in the delivery of community-based care, with a median of 88% of in-person contacts occurring in member's communities, demonstrating strong alignment with the emphasis on community-based support, rather than office-based, in the ACT model.
- No Drop Out Policy: The team demonstrated strong retention, maintaining 96% of members on the team in the past 12 months, supporting member stability.

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

- Continuity of Staffing: The team had a turnover rate of 75% in the past two years, with 18 staff leaving the team. If not done so already, attempt to identify causes for employee turnover. Optimally, turnover should be no greater than 20% over a two-year period.

- Psychiatrist on Team: The ACT team lacks a dedicated psychiatric prescriber following the departure of the previous provider, and psychiatric services are being provided by agency psychiatric providers. Hire a permanent, full-time psychiatric prescriber to serve as the team's medical director. ACT teams have at least one full-time, fully integrated psychiatric prescriber, who attends at least one program meeting per week, and sees members every 30 days or less. A dedicated prescriber ensures continuity of care, strengthens therapeutic relationships with members, and supports overall team cohesion.
- Vocational Specialist: The team does not currently have an Employment Specialist. ACT teams maintain two full-time Vocational Specialist staff with at least one year of experience providing employment supports. Ensure vocational staff receive four hours, at a minimum, of annual training in assisting people diagnosed with a serious mental illness (SMI) to find and retain employment in integrated work settings.
- Intensity of Services: Records reviewed showed an average of 30 minutes of in-person contact per week per member. Extending service duration to align with the ACT standard of at least two hours per week, tailored to each member's individual needs and recovery goals would more effectively support members in sustaining and enhancing their community functioning.
- Frequency of Services: Frequent contact is essential for positive outcomes as ACT members require regular community-based engagement to address needs and support recovery. Records reviewed showed an average of one (1) visit per week per member. Increasing contact frequency and ensuring all staff contribute to individualized, community-based engagement would likely improve member outcomes.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team currently serves 99 members and includes 7.25 full-time equivalent (FTE) direct service staff. This excludes administrative staff. The team has a member-to-staff ratio of approximately 14:1. The direct service staff consists of the CC, two Registered Nurses, one Rehabilitation Specialist, one Independent Living Skills Specialist, one Peer Support Specialist, and one Co-Occurring Disorders Specialist. At the time of the review, the Program Director .25 FTE, was providing direct support to members of the team.	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 – 5 3	Staff report that 60% of members interact with more than one ACT staff over a two-week period. The team works five days per week, eight-hour shifts with at least two specialists who work weekends to support members. Caseloads are shared amongst all specialists, with each specialist overseeing approximately 12-15 members, with responsibility to update service plans and assessments. The team uses a zone-based model, dividing the service area into eight zones that rotate among staff weekly to ensure consistent member contact. Assignments to zones rotate weekly to ensure members are being seen at least twice with a goal of four visits weekly. Members interviewed reported seeing at least one different staff weekly.	• In the EBP of ACT, 90% of members have in-person contact with more than one staff in a two-week period. Continue efforts to ensure all members on the ACT roster have in-person contact with more than one team staff every two weeks; a diversity of staff allows members access to unique perspectives and expertise staff.

			Of 10 randomly selected member records reviewed, for a month period, 60% received in-person contact from more than one staff from the team in a two-week period.	
H3	Program Meeting	1 – 5 4	The team meets in person five days per week, reviewing all members on the roster during each meeting. Attendance includes all staff scheduled to work that day, including the Program Director, a minimum of two times weekly. During the observed meeting, staff discussed member engagement, planned outreach, upcoming medical appointments with nurses and specialists, housing concerns, natural supports, and members needing additional intervention. The CC facilitated the discussion, identifying priority cases and next steps.	• ACT psychiatric prescribers attend program meetings at a minimum of once a week and stay for the duration of the meeting.
H4	Practicing ACT Leader	1 – 5 4	The CC transitioned from the CODS role in September 2025. The CC reports providing approximately 2.5–3 hours of in-person member services per day (12-15 hours weekly), while staff are expected to maintain about 30 hours per week of direct service productivity. A review of 10 member records showed the CC documented in two records providing individual co-occurring sessions and facilitating groups. One additional record showed the CC attempting a home visit. According to a productivity report for a recent 30-day period, the CC delivered 57.21 hours of direct in-person services, and 8.25 hours of telephonic services. Based on the productivity report and staff productivity expectations, the	• Continue efforts to provide in-person services to members 50% or more of the expected productivity of other ACT staff. Practicing ACT leaders can engage in a range of member care needs including providing counseling/psychotherapy, facilitating or co-facilitating co-occurring disorders treatment groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffing's, shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery.

			CC provided direct member services 48% of the expected direct service productivity time of the team. *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, 18 staff left the team resulting in a turnover rate of 75% during the past two years. The positions with the most frequent turnover during this period were the Housing Specialist, Employment Specialist, and Rehabilitation Specialist.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports the therapeutic relationship between members and staff and promotes team cohesion. • If not done so already, consider examining employees' motives for resignation, and attempt to identify factors contributing to turnover. • Continue efforts to recruit and retain experienced staff. Support staff in their specialty roles by ensuring training and guidance applicable to the specialty position is provided.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the team has operated at approximately 93% of its full staffing capacity. During this period, the Rehabilitation Specialist role was vacant for four months.	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually.
H7	Psychiatrist on Team	1 – 5 1	At the time of review, the team had no assigned psychiatric provider, as the previous provider left in September 2025. Of 10 member records reviewed, seven showed no documented psychiatric appointment, one had a completed appointment, and two indicated members were seen by an agency psychiatric provider.	• ACT teams have at least one full-time, fully integrated psychiatric prescriber assigned to serve as the medical director for the team. Prioritize filling this essential role on the team. ACT is designed for members that are typically unsuccessful with traditional case management and require a higher level of service.

H8	Nurse on Team	1 – 5 5	The team includes two full-time Registered Nurses, working a mix of four 10-hour and five 8-hour schedules. Their responsibilities include coordinating with agency psychiatric prescribers, primary care providers, assisting members with obtaining and managing medications, reviewing medication logs and Medi-sets, and supporting medication independence. Records showed nurse participation in home visits for medication management, vitals monitoring, and health education. Staff reported the nurses are readily available to the team, including after hours and weekends, via text messaging, phone, and messaging applications.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	The team includes one CODS with several years of experience providing substance use treatment. The staff is pursuing a master's degree in social work, serving the team as an intern. Agency training records provided lacked documentation of co-occurring disorders–specific training; however, university transcripts confirmed participation in a supervised internship program with clinical oversight from a qualified professional.	• Provide eight (8) hours of annual training to CODS in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *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 support 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. • ACT teams have two CODS assigned to provide services to members. When screening potential candidates for the position, consider those with one year or more of experience working with members with co-occurring disorders and integrated care.

H10	Vocational Specialist on Team	1 – 5 2	The team includes one Rehabilitation Specialist with broad behavioral health experience; however, training records lacked evidence of recent vocational-focused training. The Employment Specialist position was vacant at the time of the review.	• 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. • Optimally, 100-member ACT teams are staffed with two Vocational Specialist staff. Ensure the staffing ratio aligns appropriately with the number of members on the census.
H11	Program Size	1 – 5 3	At the time of review, the team consisted of 7.25 FTE staff, including the Program Director who maintains a small caseload. The team identified the following vacancies: Housing Specialist, ACT Specialist, Employment Specialist, Co-Occurring Disorders Specialist, and Psychiatric Prescriber.	• 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 4	The team follows *Mercy Care ACT Admission Criteria* to screen potential members. Eligible individuals must have an SMI designation, high service needs (e.g., frequent crises or hospitalizations), difficulty engaging in traditional case management, and a willingness to participate in services. Referrals are received internally or from external sources such as hospitals or the RBHA. Screenings are completed by the agency's ACT	• To strengthen adherence to ACT fidelity, ensure that screenings and admission decisions are conducted directly by the ACT team rather than agency administrative staff or covering prescriber. The ACT team should actively participate in evaluating referrals, determining eligibility, and engaging potential members to ensure that admission decisions reflect the team's

			Support Liaison, who educates potential members on service intensity and frequency. The ACT Support Liaison staffs each referral with the covering (or agency) psychiatric prescriber, who makes the final admission decision.	clinical judgment and shared responsibility for service delivery.
O2	Intake Rate	1 – 5 5	Based on data provided and reviewed with staff, the team has an appropriate rate of admission. The team accepted a total of 16 new members during the past six months, with no more than four admissions monthly.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides counseling/psychotherapy, substance use treatment, and employment/rehabilitative services. At the time of review members of the team were receiving psychiatric medication management from agency providers. Per the information provided and reviewed with staff, approximately 18 members are receiving supportive services from their residence.	*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.* • Hire a dedicated prescriber to restore the capacity of the team to deliver psychiatric services directly. • ACT teams assist members to find housing in the least restrictive environments, which can reduce the possibility for services overlapping with other housing providers. Help members explore low-income housing options to increase their housing choices. For members with backgrounds that limit the availability of housing options, consider legal measures to expunge criminal records.

O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour crisis support using a rotating on-call schedule, with one specialist assigned weekly. Nurses are excluded from the rotation, and the CC serves as backup to support staff as needed. Members access crisis support through the on-call phone number assigned to the team. Staff first attempt to telephonically stabilize members in the community to prevent hospitalization; if unable to do so by phone, they conduct in-person assessments after notifying the supervisor. The on-call psychiatric prescriber is contacted when clinically appropriate. In emergencies or unsafe situations, staff coordinate hospital transport or contact 911. Members receive a copy of the team brochure which includes the after-hours crisis number and Maricopa County crisis resources. Nurses are consulted when medication-related needs arise. Records reviewed showed the team responding to two members in crisis in their homes, providing assessment, de-escalation, and collaborating with the psychiatric prescriber for assistance. Members interviewed were largely unaware of the on-call number of the team or how to access after-hours support. One member reported calling the warm line once in the past year for assistance with transportation but typically contacts the clinic receptionist or CC during business hours. Members stated they rely primarily on the county crisis line if an emergency occurs.	• Ensure staff regularly informs members and their supports of the team on-call availability, including staff response in the community, when needed. • Provide members with the ACT on-call number in a form that is conducive to use. Some teams provide this on a business size card which also includes staff names, roles on the team, and phone number. • For members with mobile phones, consider assisting with saving the on-call phone number in their phones.

O5	Responsibility for Hospital Admissions	1 – 5 4	Staff reported the team is actively involved in all crisis situations to ensure member safety and stabilization. When a member requests hospitalization or reports the need for stabilization, staff assist with voluntary transport to the hospital and remain through admission. When a member resists hospitalization, the team consults with the covering psychiatric prescriber to evaluate risk and determine whether existing supports are sufficient. During business hours, the nearest available staff respond to member crises, with the psychiatric prescriber or nurse providing immediate consultation as needed. For increased symptoms or danger to self or other concerns, the team staffs the situation with the nurses and the psychiatric prescriber to determine if crisis stabilization or an involuntary evaluation is warranted. Staff provide or coordinate transportation and maintain involvement until the member is stabilized or admitted. Per a review of data with staff relating to the 10 most recent psychiatric hospital admissions which occurred over a three-month time frame, the team was directly involved in 70%. For admissions in which the team was not involved, members self-admitted and staff were notified afterwards.	• 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.

O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that discharge planning begins at admission. Staffing's and coordination of care with the inpatient team are completed by ACT staff to support ongoing engagement and stability. The team meets with members during inpatient stays to coordinate housing, develop crisis plans, and schedule follow-up appointments. Upon discharge, staff ensure members have medications in hand and safe placement, providing transportation home when needed. The team conducts a five-day follow-up protocol, which includes in-person visits for the first five days post-discharge and scheduling appointments with the psychiatric prescriber, nurse, and Primary Care Physician. Team specialists visit daily to assess medication compliance, confirm basic needs are met such as electricity, food, and water, and provide transportation for follow-up appointments. The team then transitions to weekly visits for two to four weeks. Based on a review of data with staff relating to the nine most recent psychiatric hospital discharges which occurred over a three-month period, staff were directly involved in 100%.	
O7	Time-unlimited Services	1 – 5 4	Data provided showed seven members graduated from the team with significant improvement in the past 12 months. Staff estimated 10% of the current roster are expected to graduate in the next 12 months.	• Since ACT teams traditionally serve those with the most complex behavioral health issues and those that have been unsuccessful in traditional outpatient services, teams strive to graduate fewer

				than five (5) percent of membership annually.
S1	Community-based Services	1 – 5 5	Staff interviewed reported that 80 - 85% of in-person contacts with members occur in the community. Results of 10 randomly selected member records reviewed showed that staff provided services with a median of 88% of the time in the community. Records showed staff conducting home visits to provide life skills training, support medical appointments, and deliver co-occurring disorder interventions. Staff also engaged with natural supports and external providers, including group home staff and probation officers, to coordinate care, update documentation, and address service plan goals. Documentation further indicated one group was held offsite at a local thrift store. Members interviewed reported varying levels of community-based engagement. Most described receiving at least one home visit per week, while one member reported a home visit only once every other month. Members noted participating in services at the clinic one to two times per week, with some reporting twice per month. Overall, members indicated most interactions with the team occur at the clinic rather than in the community.	
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had five members that dropped out of the program in the past year. The team retained 96% of the total number of members	

			served in the past 12 months. The team had one member death in the last year.	
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff reported following an eight-week outreach workflow to contact members who have disengaged from services. The process includes four contact attempts per week, with at least two occurring in person through home, community, or street outreach. Outreach efforts involve alternating between physical and digital contact, visiting known locations, coordinating with probation or parole officers, and utilizing court-ordered treatment mechanisms when appropriate. Staff also contact hospitals, shelters, and natural supports, and initiate home visits when members are unresponsive. During the program meeting observed, the team reviewed outreach plans, identified staff responsible for follow-up, and determined next steps to promote re-engagement. Of the 10 member records reviewed, seven showed gaps in contact or attempts to contact by staff ranging from 9 to 18 days.	• While the team has established a structured eight-week outreach workflow that includes multiple in-person and digital contact methods, record review revealed inconsistent application of engagement efforts. To strengthen adherence to the evidence-based model, ensure outreach attempts are consistently documented and sustained without interruption until engagement is re-established or the member declines services. Consider increasing review of outreach logs to ensure the full eight-week protocol is implemented and that contact frequency aligns with program expectations.
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 per week is approximately 30 minutes. The highest weekly average for in-person services was 691.75 minutes, while the lowest was 10 minutes.	• 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 2	Of the 10 randomly sampled records, ACT staff provided a median frequency of one (1) in-person contact to members per week. The record with the highest frequency of weekly in-person contact was nine, while two records reflected the lowest frequency at 0.25 contacts per week, or one contact during the month period reviewed. Phone contact was documented in one record, and zero records indicated videoconference support. *The fidelity tool does not accommodate delivery of telehealth services.*	• 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. • Identify and resolve barriers to increasing contacts with members. Optimally, members receive an average of four (4) or more in-person contacts a week. • Avoid over-reliance on groups to achieve contact. On ACT teams, services are individualized to meet the needs of each member.
S6	Work with Support System	1 – 5 2	Data provided identified 59 members (60%) with natural supports. Staff reported contacting natural supports at an average frequency of two to four times per month and documented in the electronic health record. During the program meeting observed, staff reported maintaining direct contact with natural support for approximately 21 members. However, member feedback varied: one member reported contact occurring once per	• 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 engagement with natural supports to an average of four (4) contacts per month for members with identified

			year, another described weekly contact, and one indicated no staff contact with natural support. Review of records indicated an average of zero contacts with natural supports within the 30-day period. Seven of the ten records reviewed pertained to members identified by the team as having natural supports.	supports, incorporating these interactions into routine service delivery. Continue to involve natural supports as active partners in recovery by modeling recovery-oriented language and providing guidance on how they can best support the member's care. • 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.
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	At the time of the review, 42 members (42%) were identified as having co-occurring disorders. Approximately 30 members were reported to participate in weekly structured individual substance use treatment provided by the CODS and the CC, each maintaining a caseload of approximately 15 members and meeting bi-weekly with most, and bi-monthly or as needed with those in the maintenance stage of change. Staff reported that members typically participate in 2–4 sessions per month, each lasting at least 30 minutes. Sessions are primarily conducted in person within the community, with some held at the clinic. Interventions described included harm reduction tactics, refusal skills, and developing recovery plans. Records reviewed showed that five of 10 (50%) sampled members were identified with co-occurring disorders. Among these five, two records documented 3 - 4 individual sessions	• Continue efforts to provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders. • Consider monitoring member engagement and participation in individual substance use treatment. • Explore training on strategies to engage members in substance use treatment. On ACT teams, all staff engage members with co-occurring disorders to participate in treatment based on their stage of change, with content reflecting stage-wise treatment approaches.

			specifically focused on substance use treatment, each lasting between 60 – 90 minutes.	
S8	Co-Occurring Disorders Treatment Groups	1 – 5 4	The team provides two substance use treatment groups weekly in-person at the clinic that are facilitated by the CODS and the CC. Staff reported that approximately 6 - 35 members with co-occurring disorders attend at least one group per month. Group sessions are not organized by members' stage of change; instead, they incorporate generalized content designed to support participants across various stages of change and recovery. Materials referenced to guide treatment include *Integrated Dual Disorders Treatment Facilitator Manual* (Hazelden), and another manual not specific to co-occurring disorders treatment. Group sign-in sheets showed that 16 unique ACT members (38%) attended at least one co-occurring treatment group in the past month. Records reviewed indicated one member participated in four groups during that period.	• 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. • Consider adapting one group for members in earlier stages and one group for members in later stages, allowing staff to adjust interventions to better serve members in various stages of change.
S9	Co-Occurring Disorders Model	1 – 5 3	Staff reported utilizing an integrated treatment model incorporating harm reduction approaches. During the observed program meeting, CODS staff discussed members' stages of change and strategies to engage members based on individual readiness. Staff emphasized meeting members where they are, supporting harm reduction practices such as using clean needles, carrying Narcan, and avoiding use alone. Staff described supporting participation in peer-run community groups and noted willingness to attend meetings alongside members when requested.	• 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.* • 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

			Staff interviewed demonstrated a basic understanding of the co-occurring disorders treatment model. Documentation in member records reflected use of traditional terminology rather than recovery focused language. Staff reported that the CODS is primarily responsible for delivering co-occurring treatment and support. Most staff noted that while abstinence is viewed as the ultimate goal, harm reduction is recognized as an important step toward promoting safety, stability, and community functioning. One staff expressed uncertainty about the overall stance of the team on abstinence versus harm reduction. The CODS is not responsible for providing training on best practices in the co-occurring disorders model used by the team. Staff reported that clinic-wide group supervision includes additional training on co-occurring disorders approximately every 2–3 months, supplementing the annual *Relias* modules. Of the five records reviewed for members with co-occurring disorders, three included treatment plans outlining substance use services such as individual sessions and group treatment with the CODS. However, only one record reflected a member-driven treatment goal. Documentation predominantly used traditional language such as "sobriety" and "relapse." Additionally, group and session notes labeled as co-occurring disorders treatment or "IDDT" lacked evidence of actual substance use related discussions and instead	the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in recovery. • Provide training to staff on how interventions are more effective when they align with a member's stage of change, i.e., a stage-wise approach. Stagewise treatment and interventions are an essential element of the Integrated Co-Occurring Disorders Treatment model.

			addressed general mental health topics such as diagnoses and symptom management.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Interviews indicated that at least three staff on the team have lived or living psychiatric experience. Staff reported that those with lived experience often have a special rapport with members through mutual understanding and shared experiences, noting that they also carry an increased sense of responsibility to ensure member safety. The team includes one certified Peer Support Specialist. One member interviewed described the presence of the peers as beneficial, stating it made them feel more comfortable opening up during casual conversation.	
Total Score:		**101**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1 - 5	5
7. Time-unlimited Services	1 - 5	4
Nature of Services	Rating Range	Score
1. Community-Based Services	1 - 5	5
2. No Drop-out Policy	1 - 5	5
3. Assertive Engagement Mechanisms	1 - 5	3
4. Intensity of Service	1 - 5	2
5. Frequency of Contact	1 - 5	2
6. Work with Support System	1 - 5	2
7. Individualized Co-Occurring Disorders Treatment	1 - 5	4
8. Co-occurring Disorders Treatment Groups	1 - 5	4
9. Co-occurring Disorders Model	1 - 5	3
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**3.61**	
Highest Possible Score	**5**	