ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

Date: July 31, 2025

To: Dr. Shar Najafi-Piper, CEO

From: Nicole Eastin, BS
Allison Treu, BS
AHCCCS Fidelity Specialists

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 July 14 – 16, 2025, Fidelity Specialists completed a review of the **Copa Health Metro Center - Omega** 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 operates five ACT teams in Maricopa County: Omega, Varsity, Medical ACT, West Valley, and Gateway. Most Copa Health clinics are designated as Integrated Care Clinics, offering on-site primary care and pharmacy services. Additional services include employment support, day programs for adults with disabilities, and residential services. In May 2024, the Copa Health Metro Center relocated to a new clinic location. The individuals served through the program are referred to as *clients* or *patients*, 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 July 15, 2025.
- Individual videoconference interview with the Clinical Coordinator.

- Individual videoconference interviews with the Housing, Employment, Independent Living Skills, and Peer Support Specialists on the team.
- Group videoconference interview with two Co-Occurring Disorders Specialists.
- Individual phone interviews with three (3) members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, ACT Manager, and representatives from AHCCCS and 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: a contractor with a Regional Behavioral Health Agreement, the Division of Developmental Disabilities, and Other (Medicare, private, other sources of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; *Mercy Care Assertive Community Treatment (ACT) Operational Manual*; copies of cover pages of substance use disorder treatment materials utilized; *Welcome to the Metro OMEGA ACT Team* information sheet; co-occurring disorders treatment group sign-in sheets; spreadsheet used to track contact with natural supports; copies of member calendars; resumes and training records for Vocational and Co-Occurring Disorders Specialist staff; and a productivity report from a recent 30-day period for the Clinical Coordinator.

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:

- Small Caseload: The team maintains a low member-to-staff ratio of 10:1, supporting an individualized service delivery approach. Staff work staggered schedules to ensure coverage, including weekends.
- Program Meeting: The team meets four days per week to discuss all the members assigned to the team. All staff, including the Psychiatrist, attend program meetings on scheduled workdays.
- Program Size: The team includes 11 staff, providing sufficient diversity and coverage for the 94 members served.
- Responsibility for Crisis Services: The ACT team provides 24/7 crisis support to members. Members interviewed were aware of the around-the-clock availability of the team and how to access support. The team provides after-hours support in the community.
- Responsibility for Hospital Admissions: The team played an active role in all (100%) of the 10 most recent psychiatric hospital admissions involving members.

- Responsibility for Hospital Discharge Planning: The team participated in 100% of the 10 most recent member psychiatric hospital discharge planning processes.

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

- Community Based Services: Increase delivery of services to members in their communities where challenges are most likely to occur. Providing services in members' natural environments allows staff to directly assess needs, monitor progress, model behaviors, and support the use of community resources. Ideally, ACT services are provided in a natural, non-clinical setting at least 80% of the time. Avoid over-reliance on clinic-based groups.
- Intensity of Service: Work with staff to increase the average weekly service time delivered to members. ACT teams delivering to fidelity of the model provide members with an average of two (2) or more hours of in-person contact weekly.
- Frequency of Contact: Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week. Ensure services are accurately documented in member records.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, there were 10 full-time equivalent (FTE) staff on the team, excluding the Psychiatrist and Program Assistant. The team serves 94 members, resulting in a member-to-staff ratio of approximately 10:1. Direct staff includes the Clinical Coordinator (CC), two Registered Nurses (Nurse), two Co-Occurring Disorders Specialists (CODS), one Rehabilitation Specialist, one Employment Specialist, one Housing Specialist, one Independent Living Skills Specialist, and one Peer Support Specialist.	
H2	Team Approach	1 - 5 4	Staff reported that at least 80% of members are seen by multiple ACT team staff within a two-week period. Most staff, including the CC, are assigned weekly to one of eight designated *fidelity contact lists*. CODS staff are assigned to a list that includes only members with co-occurring disorders who are willing to engage in individualized treatment. Staff maintain individual caseloads primarily for administrative purposes. All staff engage with members outside their *fidelity contact list* as needed, such as for specialist services, clinic/community appointments, or participation in ACT group sessions. Member contacts are documented on member calendars and reviewed during program meetings. Members interviewed confirmed regular interaction with multiple team staff throughout the week.	• Increase contact of diverse staff with members such that 90% have contact with more than one staff from the team every two weeks. ACT team staff are jointly responsible for making sure each member receives the services needed to support recovery from mental illness. Diversity of staff interaction allows members access to unique perspectives and expertise of staff, as well as the potential to reduce the burden of responsibility of member care on staff.

			Staff work staggered schedules that include either five eight-hour days or four ten-hour days. At least three staff are regularly scheduled to work weekends. Records reviewed showed documentation of staff providing services to members outside of regular business hours. Of 10 randomly selected member records reviewed for a month period, 70% received in-person contact from more than one staff from the team in a two-week period.	
H3	Program Meeting	1 - 5 5	The team meets four days weekly to discuss all the members on the roster. Staff, including the Psychiatrist, attend on scheduled workdays. During the observed program meeting, the CC led discussions on outreach and treatment planning and offering engagement strategies to the team. Staff demonstrated awareness of the stages of change and used engagement approaches tailored to individuals with co-occurring disorders, including consideration of involving natural supports. A Nurse provided updates on coordination with specialty care providers. The team also reviewed recent home and hospital visits, outreach efforts, and upcoming appointments with the Psychiatrist.	
H4	Practicing ACT Leader	1 - 5 4	The CC estimated spending approximately 40% of their time each week providing direct in-person services to members. Services include facilitating a weekly Dialectical Behavior Therapy group, conducting hospital and home visits, observing medication administration, and assisting in the facilitation of co-occurring	• Continue efforts to provide in-person services to members 50% or more of the expected productivity of other ACT staff.

			disorders groups. The CC transitioned from a CODS position on the team approximately 10 months prior to the review. The productivity expectation for in-person service delivery for team staff is approximately 25 hours weekly. According to a productivity report for a recent 30-day period, the CC provided approximately 27 hours of direct services, representing approximately 27% of the in-person service delivery standard expected of other ACT staff. Among the 10 records reviewed, there were four documented instances of the CC providing direct in-person services in four member records. These included updating annual paperwork, conducting home visits, completing a medication observation, building rapport, and encouraging group participation. Additionally, records showed six telehealth contacts, which included interactions with natural supports, inpatient facilities, group home staff, and members. *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 4	Based on information provided and reviewed with staff, the team experienced a turnover rate of 30% during the past two years. The Independent Living Skills Specialist position experienced the highest amount of turnover with two staff leaving the position.	• 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.

H6	Staff Capacity	1 – 5 5	In the past 12 months, the team has operated at approximately 96% of full staffing capacity. The Rehabilitation Specialist position experienced the highest duration of vacancy, remaining unfilled for four months.	
H7	Psychiatrist on Team	1 - 5 5	The team has a dedicated Psychiatrist that has been with the ACT team since 2012. The Psychiatrist works five days per week, including some weekends, and is responsible for assessing, diagnosing, and treating ACT members. Additional responsibilities include medication management and consultation with ACT staff, inpatient providers, and referring providers. The Psychiatrist conducts monthly in-person visits with members at the clinic and in the community and is accessible to the team via phone, email, and in person, with availability after business hours as needed. The Psychiatrist provides guidance, education, and training to ACT team staff.	
H8	Nurse on Team	1 - 5 5	The ACT team includes two Nurses that work staggered four 10-hour days. The Nurses meet with members at least once per month at the clinic and in the community. Responsibilities include coordinating care with inpatient facilities, primary care, and specialty providers; accompanying members to medical appointments; conducting nursing assessments; administering injections and labs; and managing coordination with pharmacies. The Nurses are readily accessible to the team via email, phone, and in person.	

H9	Co-Occurring Disorders Specialist on Team	1 - 5 4	The team is staffed with two CODS, each with at least one year of experience in providing substance use treatment. The CODS participate in bi-weekly clinical supervision and case consultation sessions with a licensed clinical supervisor. Based on training records provided, one CODS completed one hour of formal substance use-related training, while the other completed 4.25 hours in the past year.	• 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 and the evidence-based practice of harm reduction. The CODS support the team by cross-training staff and guiding interventions based on members' stage of treatment and the team's adopted co-occurring disorders model.
H10	Vocational Specialist on Team	1 - 5 4	The team includes one Rehabilitation Specialist and one Employment Specialist, each with at least one year of experience providing employment and vocational support. Interviews and training records did not show that these staff received recent training on best practices for supporting members in obtaining competitive employment in integrated work settings.	• Provide ongoing training, guidance, and supervision to Vocational Specialist staff, including at least four (4) hours of annual training focused on employment and vocational support services. Training should emphasize best practices that help members obtain competitive jobs in integrated settings.
H11	Program Size	1 - 5 5	At the time of the review, the team was comprised of 11 staff including the Psychiatrist. The team is of sufficient size to ensure staff diversity and adequate member coverage. One position, the ACT Specialist, was vacant due to a departure the week prior to the review.	
O1	Explicit Admission Criteria	1 - 5 5	The team utilizes the *Mercy Care ACT Admission Criteria* screening tool as formal guidance to determine eligibility for services. Screenings focus on individuals with a qualifying diagnosis that have not been successful in traditional treatment settings and/or have a high rate of psychiatric hospitalizations or incarcerations. Referrals are received from a contractor with a Regional Behavioral Health Agreement,	

			psychiatric hospitals, and internal agency sources. During the intake process, potential members are informed about the frequency, intensity, and voluntary nature of ACT services. Screenings are conducted in person by the CC and staffed with the team Psychiatrist, after collaborating with the referring agency including the psychiatric provider. Final admission decisions are made jointly by the CC and Psychiatrist. When individuals do not meet criteria, the team completes a complex case review and provides formal denial information to the referral source. Newly admitted members are introduced to all team staff upon enrollment.	
O2	Intake Rate	1 - 5 5	Per data provided and reviewed with staff, the team has an appropriate rate of admission. The month with the highest admissions during the past six months was April, with four new members added to the team roster.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management, the team provides psychiatric and medication management services, substance use treatment, and employment and rehabilitative services. All members interviewed reported that the services they receive are provided exclusively by the ACT team. The team currently lacks qualified staff to provide direct psychotherapy or counseling services, with the exception of Dialectical Behavior Therapy. Four members are receiving these counseling services through brokered providers, including agency-based counselors. The ACT team maintains regular communication	• Make counseling/psychotherapy available to members on the team provided by ACT staff. This staff will also act as a generalist within the team. Consider exploring options to provide counseling services to members of the ACT team, either through new or currently existing ACT staff. • 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

			with these providers and participates in weekly staffings to review member progress. Approximately 17 (18%) members on the team reside in settings where ACT services are duplicated. Staff reported participating in weekly coordination meetings with these providers to review progress and discuss transitions to a lower level of care when appropriate.	responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all the services and support from the team.
O4	Responsibility for Crisis Services	1 - 5 5	Based on interviews, the team provides crisis services to members 24 hours a day, seven days a week. Staff rotate weekly on-call duties, with the CC consistently serving as the designated backup. Outside of regular business hours, members are instructed to call the on-call number during a crisis. Upon receiving a crisis call, staff first attempt to assess the situation by phone. When necessary, staff meet with members in the community, conduct in-person assessments, and transport members to the hospital when appropriate. Members receive a *Welcome to the Metro Omega ACT Team* flyer, which includes clinic contact information, on-call phone numbers, and a description of individual staff roles with contact details. Members interviewed were aware of the 24/7 team availability and knew how to contact staff.	
O5	Responsibility for Hospital Admissions	1 - 5 5	Interviews and records reviewed indicate that staff are actively involved in psychiatric hospital admissions. In most cases, members are staffed with the CC and Psychiatrist to determine the	

			need for psychiatric hospitalization or stabilization. Members may be brought to the clinic during business hours for an evaluation. After hours, staff consult with the CC and/or Psychiatrist to determine appropriate next steps. When hospitalization is required, staff meet members in the community, facilitate transport to the inpatient facility, and remain present during the admission process to support a smooth transition. Based on data provided and reviewed with staff, the team was directly involved in 100% of the 10 most recent psychiatric hospital admissions which occurred over a three-month period. Staff were either present at the time of admission or were directly involved in filing a petition or requesting amendments to a court order for treatment.	
O6	Responsibility for Hospital Discharge Planning	1- 5 5	Staff reported that discharge planning begins upon admission and includes in-person visits every 72 hours, as well as weekly meetings involving the inpatient team, member, and when applicable, natural supports or guardians. The ACT team Psychiatrist and Nurse coordinate closely with inpatient providers. One of the weekly *fidelity contact lists* for the team is hospitals. The team is actively involved in the discharge process to promote a smooth transition from hospital to community-based care. Staff transport members to their pre-planned, preferred discharge location. Follow-up care is prioritized with psychiatric and nursing	

			appointments scheduled for the day following discharge, and a 5-day in-person follow-up protocol during which staff meet with members daily in the community. Based on data provided and reviewed with staff, the team was directly involved in discharge planning for 100% of the 10 most recent psychiatric hospital discharges over a three-month period.	
O7	Time-unlimited Services	1 - 5 5	Data provided and reviewed with staff indicated that three members (3%) graduated from the team with significant improvement in the past 12 months. Staff reported that when members appear to be approaching graduation, the topic is discussed during program and treatment team meetings. The team collaborates with members and/or guardians to review options and make recommendations based on clinical input and member readiness.	
S1	Community-based Services	1 - 5 3	Staff interviewed reported that between 30% and 90% of in-person contacts with members occur in the community. Members interviewed confirmed frequent community-based engagement, reporting staff presence in the community between three to seven days per week. Documentation reviewed reflected a range of community-based services, including home visits; medication observation in the morning and evening hours; transportation to and from hospital admissions and discharges; visits to members during psychiatric and medical hospitalizations; and facilitation of community-based groups, such as food bank visits.	• 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.

			A review of 10 randomly selected member records showed that staff provided services a median of 50% of the time in the community.	
S2	No Drop-out Policy	1 - 5 4	According to data provided and reviewed with staff, 12 members (10%) left the program over the past year, resulting in a 90% retention rate. Of those who left, one declined service, four could not be located, and seven were transitioned to a higher level of care, such as behavioral health residential facilities.	• ACT teams ideally retain 95% of the entire caseload yearly. Work to retain membership in ACT. Several factors can impact this number positively including assertive engagement practices and taking a recovery perspective and client-centered approach with member care.
S3	Assertive Engagement Mechanisms	1 - 5 4	Staff described using a team-based approach to engagement, in which the specialist with the strongest rapport with a member leads the outreach efforts. To promote engagement, staff offer a wide range of services tailored to members' interests and needs, including access to community resources and participation in recreational and social activities. Examples include community outings and events featuring groups such as Peer Support, Lunch Bunch, Bingo, Food Bank, and *Art of Our Soul*. When staff are unable to locate or have lost contact with members, they rotate weekly to cover a designated outreach *fidelity contact list*. Staff assigned to this list are responsible for conducting outreach attempts, which include a minimum of four contact attempts per week for at least eight consecutive weeks prior to the team considering the member transition to a lower level of care (Navigation). Outreach efforts involve community-based searches at members' last known addresses, frequented locations, and shelters; phone calls and web searches with hospitals, jails, and the medical examiner's	• When members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Continue to discuss and track these efforts during the program meeting. Consider peer review of documentation to ensure efforts are accurately included in member records.

			office; and contact with natural supports, probation officers, and guardians to gather updates or facilitate re-engagement. Among the member records reviewed, two showed gaps of 13 to 20 days with no documented in-person or phone engagement attempts.	
S4	Intensity of Services	1 - 5 2	Per 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 39.63 minutes. In this sample, in-person contact ranged from a low of 13.75 minutes to a high of 284.5 minutes per week. Phone contact was documented in 70% of the records, with members receiving a median of 1.5 calls per month. The median duration of these calls was approximately 3.5 minutes. Additionally, the Psychiatrist provided telehealth services (audio and video) to two members during the review period. *The fidelity tool does not accommodate delivery of telehealth services with the exception of the Psychiatrist.*	• Increase the duration of services delivered to members. ACT teams provide an average of two (2) or more hours of in-person services per week to help members with serious symptoms maintain and improve functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 2	Of the 10 randomly sampled records, ACT staff provided a median frequency of 1.13 in-person contacts with members per week. The record with the lowest frequency averaged 0.25 in-person contacts per week, while the highest averaged 9.25 contacts per week.	• Increase the frequency of contact with members by ACT staff, optimally averaging four (4) or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have diverse needs/goals and frequency of

			Members interviewed reported daily in-person contact with staff.	contact should be determined by those needs and immediacy. • Consider implementing a peer review process for documentation to ensure staff efforts are accurately reflected in member records. • Ensure member calendars consistently and accurately capture both contacts and outreach attempts made by ACT team staff.
S6	Work with Support System	1 - 5 4	Data provided by the team identified 73 members (78%) as having natural supports. Staff reported regularly connecting with these supports through phone calls, emails, clinic appointments, and home visits. Staff provided varied reports regarding both the number of natural supports involved with the team and the frequency of their contact. During the observed program meeting, the team discussed contact with approximately 23 (32%) members' natural supports. Of the members interviewed, two reported no staff contact with their natural supports. The third member reported limited contact except during periods of intensive service need and that contact with their natural support was described as consistent. Records reviewed showed an average of 2.30 contacts with members' natural supports over a 30-day period. Eight of the 10 records reviewed were for members identified by the team as having natural supports. Of these, four records documented contact with natural supports, with	• 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. • Evaluate methods of tracking or monitoring staff documentation of contacts with Natural Supports. Consider tracking contacts during the program meeting on member calendars.

			two reflecting 4 - 17 contacts within a 30-day period.	
S7	Individualized Co-Occurring Disorders Treatment	1 - 5 4	Per interviews and data provided, 50 (53%) of members were identified with co-occurring disorders. Of those, staff reported approximately 32 (64%) receive weekly individualized Integrated Dual Diagnosis Treatment, or more currently referred to as Integrated Treatment for Co-Occurring Disorders sessions, with each session typically lasting at least 24 minutes. Members with co-occurring disorders that have expressed interest in substance use treatment are placed on a rotating contact list, also referred to as the CODS *fidelity contact list*. The list is divided in half, with each CODS staff assigned to one group which rotates weekly, ensuring those members are seen by each CODS staff over the course of the month. CODS attempt to engage members who have not expressed an interest in treatment during routine service interactions, such as when they attend clinic appointments and group sessions. Of the 10 records reviewed, five were of members with co-occurring disorders. Of these, three showed members receiving one to five individualized treatment sessions within a 30-day period, each lasting more than 24 minutes. Two additional records documented CODS staff efforts to engage members in treatment, either directly or through coordination with agency counselors.	• Continue efforts 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. • Include all members with co-occurring disorders in the CODS *fidelity contact list* to provide them with an opportunity to engage with CODS staff. • All staff on ACT teams are responsible for engaging members with co-occurring disorders to consider participating in substance use treatment. Explore training on strategies to engage members. • Follow a trauma-informed approach with members by promoting continuity of care and fostering respectful, thoughtful therapeutic rapport. Minimize the need for members to repeatedly share their history with multiple CODS staff by providing the option to work with a single CODS staff.

			Based on member calendars provided, 27 members received individual substance use treatment sessions during a recent month. Of these, one member received four sessions, three members received three sessions, eight received two sessions, and fifteen members received one session.	
S8	Co-Occurring Disorders Treatment Groups	1 - 5 4	Staff interviewed indicate that the team offers three weekly groups which follow an integrated co-occurring disorders treatment model to members with co-occurring disorders, facilitated by CODS staff. Manuals used to treat members with co-occurring disorders include *Integrated Dual Disorders Treatment (IDDT)* and the *IDDT Recovery Life Skills Program,* Hazelden*,* and other manuals not specific to treating co-occurring disorders. Sign-in sheets from the month prior to the review showed that 18 (36%) of unique members with co-occurring disorders attended these groups.	• Utilize all ACT staff to engage members with co-occurring disorders to participate in group substance use treatment, as appropriate, based on their stage of change. Ideally, 50% or more of applicable members participate in co-occurring disorders group monthly.
S9	Co-Occurring Disorders Model	1 - 5 4	Some staff described using a harm reduction approach to support members with co-occurring disorders, including nonjudgmental, flexible engagement, exploring stages of change, and identifying strategies to reduce use. Staff also reported referring members to detoxification programs when medically necessary and assisting those seeking peer-run substance use programs. Some staff were unclear on how the team supports members beyond referring them to the CODS staff. CODS staff reported using a stage-wise, integrated co-occurring disorders treatment model approach, assessing each member's stage	• 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.* • Support CODS staff to provide the team with mentoring and modeling of an integrated co-occurring disorders model. Providing daily support to the team in best practices may improve the level of engagement and quality of services of members.

			of change and tailoring interventions accordingly. Engagement typically begins with rapport-building and progresses to individual or group services, with an emphasis on encouraging members' motivation toward goal setting. Staff apply a strengths-based approach and Cognitive Behavioral Therapy. During the program meeting, staff discussed members' stages of change and collaboratively identified next steps for interventions. Of five records reviewed for members with co-occurring disorders, two included treatment plans that addressed both mental health and substance use. One plan identified substance use disorder as a barrier to care and included a referral for residential treatment as the intervention. Two plans lacked substance use treatment goals; however, one of those documented staff engagement and encouragement to participate in individual sessions and groups while the member was hospitalized. Staff reported no formal opportunities for CODS staff to provide training to the team; however, informally they share insights. Several ACT staff, beyond the CODS, have prior experience supporting individuals with co-occurring disorders, which contributes to ongoing informal discussions. *Relias* training related to co-occurring disorders is assigned by the agency.	

S10	Role of Consumers on Treatment Team	1 - 5 5	Staff interviewed indicated that the team includes at least one staff with lived or living psychiatric experience. This staff appropriately shares personal recovery experiences to promote hope and engagement and provides valuable insight by identifying services that were most beneficial during their own recovery journey.	
Total Score:		**120**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1 - 5	5
7. Time-unlimited Services	1 - 5	5
Nature of Services	Rating Range	Score
1. Community-Based Services	1 - 5	3
2. No Drop-out Policy	1 - 5	4
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	4
9. Co-occurring Disorders Model	1 - 5	4
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**4.29**	
Highest Possible Score	**5**	