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 September 8 – 10, 2025, Fidelity Specialists completed a review of the **Copa Health Metro Center – Varsity** 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 multiple outpatient centers designated as Integrated Care Clinics, offering on-site primary care, pharmacy services, employment support, day programs for adults with disabilities, residential services, and five ACT teams across Maricopa County. 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 activities:

- Remote observation of an ACT team program meeting on September 9, 2025.
- Individual videoconference interview with the Clinical Coordinator (CC).

- Individual videoconference interviews with the Peer Support Specialist, Rehabilitation Specialist, Independent Living Specialist, and two Co-Occurring Disorders Specialists (CODS) for the team.
- Individual phone interviews with three (3) members participating in ACT services with the team.
- Closeout discussion with the CC, ACT Program Director, and representatives from the Arizona Health Care Cost Containment System (AHCCCS) 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, Division of Developmental Disabilities, and Other (Medicare, private, or other source of coverage).
- Review of documents: *ACT Admission Criteria*; outreach protocol and tracking sheet; *Mercy Care ACT Operational Manual*; member welcome handout/staff contact list; copies of cover pages of substance use disorder treatment materials utilized; member calendars; co-occurring disorders treatment group sign-in sheets; resumes and training records for the Vocational and Co-Occurring Disorders Specialist staff; and a productivity report for the CC from a recent 30-day period.

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

- Program Meeting: The team meets in person four days per week to review all members on the roster; all staff attend on their scheduled workdays, the prescriber attends at least once weekly, and the CC provides regular clinical direction to prioritize service delivery based on member need.
- Psychiatrist on the Team: The team has a dedicated psychiatric prescriber that has been in the role for approximately eight months and provides services to members in the office and in the community.
- Intake Rate: The team maintained an appropriate admission rate, enrolling nine new members in the past six months with no more than three admissions in any month.
- Responsibility for Hospital Discharge Planning: The team was involved in all recent psychiatric hospital discharges, providing coordinated follow-up, timely prescriber and nursing appointments, transportation, and daily post-discharge safety check-ins to members.
- No Drop Out Policy: The team demonstrated strong retention, maintaining 98% of members with only two members leaving 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/Staff Capacity: Ensure vacant positions are promptly filled with qualified staff, with the goal of operating at 95% or more of full staffing annually and keeping turnover below 20% over a two-year period. Support specialty staff through supervision and training in their area of expertise to promote retention.
- Vocational Specialist on the Team: Ensure that the Employment and Rehabilitation Specialists receive a minimum of four (4) hours of annual training on best practices in employment and vocational support services that promote members obtaining competitive jobs in integrated settings.
- Full Responsibility of Treatment Services: Integrate all service delivery through the ACT team by ensuring specialists are trained and cross-trained to provide core components of ACT, including case management, psychiatric services, counseling/psychotherapy, employment and rehabilitation services, housing support, and substance use treatment. The team did not include qualified staff to provide counseling or psychotherapy to members, and at least 10% of the member roster received housing support services and substance use treatment from brokered providers.
- Work with Support System: Increase contacts with natural supports to an average of four (4) per month for each member with an identified support system, incorporating these contacts into the natural course of service delivery whenever possible and ensuring all contacts are documented in the member record.
- Individualized Co-Occurring Disorders Treatment/Co-Occurring Disorders Treatment Groups: Increase member engagement in substance use treatment services delivered through the ACT team. Use evidence-based curriculum and materials to provide both individualized and group services to members with co-occurring disorders, ensuring an average of 24 or more minutes per week of individualized treatment for applicable members and at least 50% attending one treatment group monthly.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, the team served 92 members and included nine (9) full-time equivalent (FTE) direct service staff, excluding the psychiatric prescriber and administrative personnel. The team had a member-to-staff ratio of 11:1. Positions on the team included the CC, two Registered Nurses (RN), two CODS, one Rehabilitation Specialist, one Employment Specialist, one Independent Living Specialist, and one Peer Support Specialist.	• Ensure necessary staffing to maintain a member-to-staff ratio of no greater than 10:1, excluding the psychiatric prescriber, by prioritizing the filling of vacant positions. A small caseload size supports individualized, intensive services and reduces staff burden.
H2	Team Approach	1 – 5 5	Staff reported that at least 80% of members interact with more than one ACT staff within any two-week period. The team reported using a geographic zone approach to ensure contact with members, with five zones, including one designated for members on outreach or that were hospitalized or incarcerated. Zones are rotated weekly among specialists, excluding nurses and the psychiatric prescriber. Contact is tracked on member calendars and monitored by the CC during the program meeting. Staff reported carrying caseloads of approximately 15 members. Caseload responsibilities included administrative tasks (e.g., appointment reminders and annual paperwork updates) and ensuring regular contact with members and their natural supports.	

			Members interviewed reported interacting with one to five staff each week. Of 10 randomly selected member records reviewed for a one-month period, 100% showed in-person contact with more than one ACT staff within a two-week period.	
H3	Program Meeting	1 – 5 5	Staff reported the team meets in person four days per week to review all members on the roster, with all staff expected to attend on scheduled workdays and the psychiatric prescriber attending at least once weekly. During the observed program meeting, staff discussed recent engagement efforts and planned outreach activities. Topics included member engagement in treatment, stages of change and treatment, medication management updates, group participation, contact with natural supports, and coordination for members that were hospitalized or incarcerated. The CC facilitated the meeting by announcing member names from the roster, updating member calendars, and providing clinical guidance to prioritize service delivery.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimated spending 85% of their time providing direct services to members, including crisis response in the community, transportation to hospitals, facilitating discharges, medication delivery and observation, jail visits, and clinic-based group facilitation. During the observed program meeting, the CC reported to have contacted or attempted contact with approximately 46% of members on the roster; at	• Continue efforts to provide in-person services to members by ensuring the ACT CC delivers direct services at a level equivalent to at least 50% of the expected productivity of other ACT staff, with evidence documented in member records. Reassign non-essential administrative functions to the program assistant or other team staff so the CC can prioritize

			least two contacts occurred via telehealth. Reported activities included participation in hospital staffings and court hearings, skill building in the community, and completion of annual paperwork in the clinic. The productivity expectation for in-person service delivery for team staff is 30 hours per week. A productivity report for a recent 30-day period showed the CC delivered 11 hours of direct services, or approximately 37% of the expected standard for other ACT staff. Of the 10 records reviewed, two documented the CC providing direct services, including medication prompts and facilitating an art group at the clinic. The CC was also referenced in two additional records documented by team staff, indicating the CC's participation in a hospital staffing and receipt of a warm handoff following a crisis response; however, these references do not count toward direct service provision, as they were not documented by the CC. *The fidelity tool does not accommodate delivery of telehealth services.* *This item is dependent on the Provider productivity expectation.*	direct service delivery, documentation, and modeling effective clinical interventions that support member outcomes.
H5	Continuity of Staffing	1 – 5 3	Based on information provided and reviewed with staff, 10 staff left the team in the past 24 months, resulting in a turnover rate of 42%. The Independent Living Specialist and CODS positions experienced the highest amount of turnover.	• Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their natural supports, as well as reducing the potential burden on staff.

			Members interviewed expressed confusion regarding staff on the team.	• 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.
H6	Staff Capacity	1 – 5 3	During the past 12 months, the team operated at approximately 79% of full staffing capacity, with a total of 30 vacancies during this period. Current vacancies include the Housing and ACT Specialist positions. The psychiatric prescriber position was vacant for two months, and the CC position for one month. One CODS position was vacant for six months, with both CODS positions vacant concurrently for one of those months. The ILS position was vacant for five months, and the Peer Support Specialist position remained unfilled for eight months, representing the longest vacancy on the team.	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible with the goal of operating at 95% or more of full staffing annually. The timely filling of vacant positions also helps to reduce the potential burden on staff.
H7	Psychiatrist on Team	1 – 5 4	The team includes a 0.98 FTE Psychiatric Mental Health Nurse Practitioner (PMHNP) that serves the 92 members on the roster, with approximately 10% of their time dedicated to non-ACT members. Staff reported that the PMHNP works a four-day, 10-hour schedule and is accessible to the team through messaging platforms, phone calls, text messaging, email, and in person. Staff and members indicated that psychiatric appointments occur monthly, with additional visits scheduled based on need. Staff reported that ACT members receive PMHNP services in person at the clinic, in the	• Increase the time the psychiatric prescriber is assigned to the team. ACT teams with a 100-member roster have one full-time Psychiatric Prescriber assigned.

			community, or via videoconference depending on member need, while members reported appointments occurred primarily at the clinic. Of the 10 records reviewed, all showed members received services from the PMHNP at least once in a 30-day period, with three (30%) indicating multiple visits.	
H8	Nurse on Team	1 – 5 5	The team is staffed with two full-time RNs that are accessible to staff through messaging platforms, phone calls, text messaging, email, and in person. Responsibilities include coordinating care with the PMHNP, specialty providers, and primary care physicians; transporting members to specialty care appointments; and providing medication education and delivery in the community. Nurses also conduct home and hospital visits, monitor vitals, administer injections, and update the team on members' ongoing medical conditions. Of the 10 records reviewed, nine showed members received nursing services at least once in a 30-day period, and four of those indicated the services occurred in the community.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	The team includes two full-time CODS, both with several years of previous experience providing substance use treatment. At the time of the review, both CODS staff were new to the team. Training records provided indicated that each completed one hour of training related to substance use or co-occurring disorders treatment within the past 12 months. Both received group clinical supervision from a	• 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 the members'

			Licensed Independent Addiction Counselor (LIAC) twice monthly.	stage of change and the co-occurring disorders model adopted by the team.
H10	Vocational Specialist on Team	1 – 5 2	The team includes one Employment Specialist and one Rehabilitation Specialist. The Employment Specialist had been in the role for approximately one year and had approximately two years of prior experience supporting individuals in obtaining or maintaining employment in integrated work settings. The Rehabilitation Specialist joined the team nine months prior to the review and had no previous experience in the field. Training records indicate that neither specialist has received four hours of training related to vocational and employment support services in the past 12 months.	• ACT teams maintain Vocational Specialist staff with at least one year of experience providing employment support. • 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. 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 5	At the time of the review, the team was comprised of 10 FTE staff, including the PMHNP, and was sufficiently sized to adequately provide services to members. Vacant positions included one ACT Specialist and one Housing Specialist.	
O1	Explicit Admission Criteria	1 – 5 5	Per interviews, the team screens new referrals using the *Mercy Care ACT Admission Criteria*. Eligible members must have a serious mental illness (SMI) designation, demonstrate limited success in traditional mental health services, present with high service needs (e.g., frequent hospitalization or chronic homelessness), and be willing to participate in services. Referrals may originate internally from agency teams or externally from regional behavioral health contractors or local hospitals. Upon receipt of a referral, completed transfer packet,	

			and release of information, the team has 72 hours to coordinate and schedule the screening. The CC is primarily responsible for conducting screenings and consults with the PMHNP upon completion. The PMHNP typically obtains additional information through prescriber-to-prescriber consultations with the potential member's current clinic. The CC and PMHNP jointly determine the final admission decision. Once approved, the CC updates the team and notifies the referring provider of the date and time for the member's transfer to the ACT team.	
O2	Intake Rate	1 – 5 5	Based on data provided and reviewed with staff, the team maintained an appropriate rate of admission, accepting nine new members in the past six months with no more than three admissions in any single month.	
O3	Full Responsibility for Treatment Services	1 – 5 3	*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.* In addition to case management, the team provides psychiatric services and medication management and employment/rehabilitative support. The team does not include staff qualified to provide counseling or psychotherapy to members. Per interviews, approximately 10	• Reduce reliance on external agency staff and programs by identifying opportunities for the ACT team to provide services directly. Members benefit when services are integrated within a single team, rather than dispersed across multiple providers. • Make counseling/psychotherapy available to members on the team provided by ACT staff. This staff will also act as a generalist within the team. Ensure future staffing includes a person qualified to provide counseling/psychotherapy to members. • 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

			members (11%) receive counseling services from external agency providers. At the time of the review, approximately 17 members (18%) were housed in settings such as behavioral health residential treatment facilities and group homes, where a duplication of ACT services occurred. Per interviews, the team serves 55 members with co-occurring disorders. Of those, two members were receiving services from external residential treatment facilities, and seven (13%) were regularly attending substance use treatment groups facilitated by staff from another ACT team within the agency.	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 the services and support from the team. • Make available the delivery of co-occurring disorders treatment to members of the ACT team. ACT teams fully assume responsibility for providing members with formal substance use treatment in an integrated setting, staying within the team approach of the EBP.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour crisis support through a rotating on-call schedule, with one staff assigned each week. All staff, excluding the RNs and PMHNP, participate in the rotation. Crisis support is delivered by phone or in person, depending on member needs. When members call after hours, staff assess for danger to self or others, first attempting de-escalation by phone before responding in the community when necessary. When de-escalation is unsuccessful, staff contact the CC to plan next steps. Situations resolved without hospitalization are followed by scheduling the member with the PMHNP at the earliest availability. When hospitalization is required, staff transport the member to the hospital and remain present through admission.	

			Members are provided with a handout that includes the on-call phone number in large font, the office phone number and hours of operation, team specialist roles, the names of staff in each role, and staff work cell phone numbers. The three members interviewed confirmed access to staff outside of business hours, including evenings and weekends. One member reported using the warm line when unable to reach on-call staff.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported the team is actively involved in all psychiatric hospital admissions. During crises, staff conduct a preliminary assessment of the member in the community, at the clinic, or by phone. An RN then completes an evaluation and consults with the PMHNP as needed. Members that agree to an appointment are scheduled with the PMHNP as soon as possible. When hospitalization is necessary, staff first seek member consent; if the member lacks insight, the CC, RN, and PMHNP collectively determine next steps, which may include initiation of the involuntary petition process. Staff support members through admissions by providing transportation and coordinating with hospitals and natural supports. Per a review of data relating to the 10 most recent psychiatric hospital admissions that occurred over a 39-day period, the team was directly involved in 50%. Of the admissions without team involvement, one member was petitioned for court-ordered evaluation by	• 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. • Develop hospitalization plans with members in advance, especially when they have a history of hospitalization without seeking team support.

			natural supports, and four self-admitted without team knowledge.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that discharge planning begins at admission. The team coordinates with inpatient staff by providing medication lists and psychiatric provider notes and facilitating prescriber-to-prescriber communication. Natural supports and guardians are updated, initial and follow-up staffings are scheduled, and staff assess discharge planning needs during member visits that occur every 72 hours. When needed, the team also identifies appropriate placement options for discharge. ACT staff are present at all discharges to obtain paperwork, assist members with filling prescriptions, and provide transportation to planned placements. Following discharge, the team implements a five-day follow-up protocol that includes daily in-person or phone contact from a specialist, an appointment with the PMHNP within 72 hours, and an appointment with an RN within one week. During the program meeting observed, staff discussed hospital discharge planning and follow-up efforts. Per a review of data with staff relating to the 10 most recent psychiatric hospital discharges that occurred over a 51-day period, the team was directly involved in 100%.	
O7	Time-unlimited Services	1 – 5 5	Data provided showed five members graduated from the team with significant improvement in the past 12 months. Staff estimated five to six members are anticipated to graduate in the next 12 months.	

			During the observed program meeting, three members were identified as requesting or expressing interest in stepping down to a lower level of care.	
S1	Community-based Services	1 – 5 3	Staff interviewed reported that 50 - 90% of in-person contact with members occurs in the community. Of the three members interviewed, all reported seeing staff most frequently at the clinic. Results of 10 randomly selected member records reviewed showed staff provided services in the community a median of 59% of the time. Records showed one RN provided services to members in the community, including home visits and transporting members to specialty providers, accompanying them during appointments, and providing transportation to and from community and clinic visits. Specialists also delivered community-based services such as home visits, providing skills training, supporting members in telehealth PMHNP appointments, visiting members in the hospital, and participating in hospital staffings.	• 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 accessing resources in a natural, non-clinical setting. • Avoid over-reliance on clinic-based contacts with members as a replacement for community-based contacts. Members of ACT teams find limited success with traditional, office-based treatment.
S2	No Drop-out Policy	1 – 5 5	According to data reviewed with staff, two members left the program in the past year, both due to moving out of state without a referral. Staff reported contacting the Medicaid program in one state to assist a member in connecting to services but were unsuccessful. The team retained 98% of members served in the past 12 months.	

S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reported using multiple assertive engagement strategies to retain and re-engage members, including offering appealing groups, conducting street outreach, and coordinating with natural supports and probation or parole officers. When members miss appointments or cannot be located, the team makes at least four outreach attempts per week for up to eight weeks. Two attempts are conducted in the community and two by phone or electronic means. Outreach efforts included visiting members' last known address, checking shelters, visiting frequented locations such as convenience stores, and contacting natural supports, guardians, hospitals, jails, probation and parole officers, and the morgue. During the program meeting observed, the team discussed outreach attempts and plans for approximately six disengaged members, identifying staff responsible for follow-up and anticipated contact locations. Reviewers were provided with an eight-week checklist, as well as an agency document used by the team as a protocol, outlining weekly outreach expectations and appropriate re-engagement strategies for members on ACT teams as well as supportive teams. Of the 10 records reviewed, two (20%) showed lapses in engagement, with no documented outreach attempts for 8 to 12 days.	• 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.

S4	Intensity of Services	1 – 5 4	Records reviewed indicated that during a 30-day period before the fidelity review, the median amount of time the team spent in person with members per week was 94.25 minutes. The highest weekly average for in-person services was 264.5, while the lowest was 45.5. Some documentation in member records lacked sufficient detail to capture the nature of the interventions provided or the members' experience of services.	• ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. Ensure services are accurately documented.
S5	Frequency of Contact	1 – 5 3	Of the 10 randomly sampled records, ACT staff provided a median frequency of 2.5 in-person contacts per member per week. The highest frequency averaged 6.5 contacts per week, while the lowest, reflected in two records, averaged 1.75 contacts per week. Phone contact was documented in 70% of records, with a median of one contact per month. Three records showed the team provided videoconference support up to twice monthly, including telehealth appointments with the PMHNP. Across all telehealth methods, the combined median duration was 5.63 minutes. In 60% of records, members received services from non-ACT staff two to five times during the 30-day period reviewed. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. • Eliminate the utilization of agency staff to conduct the essential service of engaging with members assigned to the ACT team. Members on ACT teams are not successful with traditional mental health services and require frequent and individualized services based on an integrated treatment team approach.
S6	Work with Support System	1 – 5 2	Data provided identified 35 members (38%) with natural supports. Staff reported varied accounts of engagement. One reported approximately 15 member supports were engaged by staff in the	• Engage members' natural support systems as key contributors to the recovery team by increasing contacts with supports to an

			past 30 days, noting the goal is weekly in-person contact. Another staff expressed uncertainty regarding the number of supports engaged by the team in the past 30 days but cited recent contact with three member supports. A third staff reported engagement occurs infrequently. All three members interviewed reported the team has regular contact with their natural supports. One member stated their natural support typically communicates with the team once weekly, while two others reported that their supports engage with staff when home visits occur. The team discusses natural support contact during program meetings and reports documenting those contacts in the member records. In the observed meeting, staff reported direct contact with supports for at least 19 members, 74% of which occurred in person at the clinic or in community settings. Records reviewed showed an average of 0.30 contacts with natural supports over a 30-day period, with two records indicating one or two instances of staff interaction with natural supports.	average of four (4) per month for each member with a support system. • 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. • Ensure consistent documentation of contacts with natural supports, including phone, email, text, and in-person interactions, and consider monitoring this documentation through review and tracking during program meetings.
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 3	At the time of the review, 55 members were identified with co-occurring disorders. Of those, staff reported one member had participated in one 30-minute structured, individualized substance use treatment session.	• Increase the number of members engaged in individualized substance use treatment and work to provide an average of 24 minutes, or more, per week of structured individualized substance use treatment services for all members with co-occurring disorders.

			Staff reported that CODS staff were building rapport with members with co-occurring disorders. CODS staff carry caseloads and reported approximately 75% of the caseload consisted of members with co-occurring disorders. Of the records reviewed, four were members with co-occurring disorders. Of those, three reflected CODS staff engagement through home visits, phone calls, or groups. Additionally, several records showed documentation of Varsity ACT CODS staff discussing members' substance use history, length of sobriety, and preferences for substance use treatment facilities.	• Evaluate whether CODS participation in other duties, such as monitoring engagement of members on an assigned caseload, limits their ability to provide individual substance use treatment. Consider shifting those duties to other staff when indicated.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 1	At the time of the review, the team was not facilitating co-occurring disorders treatment groups for members of the team. Staff reported that another ACT team facilitated a "chemical dependency" group that meets three times weekly for three hours. Per interviews and records reviewed, team CODS staff had been shadowing these groups for three weeks with the intention of assuming facilitation. Approximately seven members (13%) with co-occurring disorders were attending. Of the four records reviewed for members with co-occurring disorders, one (25%) reflected regular participation. Staff further reported that facilitators use curriculum from SAMHSA and Hazelden.	• Develop the capacity to provide co-occurring disorders treatment groups for members of the team. 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.

S9	Co-Occurring Disorders Model	1 – 5 3	Some staff reported applying a stage-wise approach to support members with co-occurring disorders, while other staff reported that members are provided support through connection to community resources and encouragement to participate in the "chemical dependency" group. Some staff expressed unfamiliarity with the approach the team utilizes and uncertainty about whether the focus was on abstinence or harm reduction. Per interviews, staff refer members to detoxification centers, residential or substance use treatment programs, and peer-run community meetings as needed or upon request. Per interviews, harm reduction strategies utilized by CODS staff included sharing resources for clean syringes with members that use substances intravenously, connecting a heavy smoker with smoking cessation classes, and encouraging the reduction of alcohol consumption. During the observed program meeting, CODS staff identified the stages of change for some members and used that framework to guide engagement and interventions. Of the four records reviewed for members with co-occurring disorders, three included current treatment plans, while one had been expired for nearly one year. All treatment plans were written in a system-focused format, identifying service categories and staff responsibilities, rather than using person-centered language to reflect	• 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 the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in recovery. • Model recovery-focused language when engaging members in discussions about substance use. 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.

			members' goals and desired outcomes. None of the three current plans included substance use treatment goals. Additionally, the fourth record lacked evidence of a substance use diagnosis yet contained a future recommendation for assessment and treatment of a substance use disorder.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team includes at least one staff with lived or living psychiatric experience that shares their recovery journey with members when appropriate. The three interviewed members were not aware of peer staff on the team. Members expressed feeling confused by the influx of new staff on the team.	Consideration: Ensure efforts are made to educate members, as applicable and appropriate, about staff on the team with lived experience who may serve as a resource.
Total Score:		**107**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1 - 5	5
7. Time-unlimited Services	1 - 5	5
Nature of Services	Rating Range	Score
1. Community-Based Services	1 - 5	3
2. No Drop-out Policy	1 - 5	5
3. Assertive Engagement Mechanisms	1 - 5	4
4. Intensity of Service	1 - 5	4
5. Frequency of Contact	1 - 5	3
6. Work with Support System	1 - 5	2
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	**3.82**	
Highest Possible Score	**5**	