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 **Valleywise Health - Maryvale** Forensic ACT (FACT) team. This review is intended to provide specific feedback on the development of your agency's FACT services in an effort to improve the overall quality of behavioral health services in Maricopa County.

Valleywise Health has provided behavioral health services for more than 50 years. The organization operates multiple sites across Maricopa County, including Community Health Centers, First Episode Centers, and ACT and FACT teams, offering a comprehensive range of integrated inpatient and outpatient services. This review focuses on the Valleywise Maryvale FACT team, established in June 2024, and represents the first fidelity review for this team. The individuals served through the program are referred to as *clients* or *members*, but for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

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

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

- Individual videoconference interview with the Clinical Coordinator (CC).

- Remote observation of the FACT team program meeting on October 14, 2025.
- Individual videoconference interviews with the Housing, Rehabilitation, ACT, and Peer Support Specialists for the team.
- Group videoconference interview with two (2) Co-Occurring Disorders Specialists (CODS) for the team.
- Individual phone interviews with members participating in services with the FACT team. Three (3) of the five members provided were successfully contacted.
- Closeout discussion with the CC, Director of Outpatient Behavioral Health Services, Quality Assurance Analyst, and a representative 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 and Long-Term Care.
- Review of documents: *Mercy Care FACT Admission Criteria;* Mercy Care Assertive Engagement Mechanisms*; Outreach Rotation* schedule*; F-ACT On-Call Card; Staff Phone List; Integrated Dual Disorders Treatment Facilitator Manual (Hazelden)* cover page*;* member calendars*;* resumes and training records for both Vocational and CODS staff*;* a CC productivity report from a recent 30-day period; and a clinical oversight sign-in sheet for June 2025.

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:

- Continuity of Staffing: Since its inception, the FACT team has maintained consistent staffing, experiencing only a 6% turnover rate since June 2024.
- Psychiatrist on the Team/Nurse on the Team: The team includes one Psychiatrist and two Nurses that work exclusively with FACT members. The Psychiatrist and Nurses participate in program meetings on their scheduled workdays, are available for spontaneous collaboration with each other and team staff, and provide in-person services to members in both the community and clinic. We commend Valleywise for setting the expectation that a psychiatrist holds the important role as the Medical Director of the forensic-based program delivering services to members who are at higher risk than traditional ACT participants.
- Explicit Admission Criteria: The FACT team follows clearly identified admission criteria and uses the *Mercy Care FACT Admission Criteria* to screen all potential referrals. Final admission decisions are made by the team Psychiatrist.

- Responsibility for Crisis Services: The team maintains two on-call lines, one primary and one backup, for members to call when experiencing a crisis after hours. Records showed staff informing members of the 24-hour availability of the team, and member interviews confirmed that staff are accessible after hours.
- Assertive Engagement Mechanisms: The team utilizes an *Outreach Rotation* schedule that outlines the re-engagement efforts to be completed each day. The schedule is rotated daily, and all staff interviewed demonstrated a thorough understanding of the outreach protocol for the team.
- Work with Support System: The team recognizes natural supports as an important component of member care and provides resources and support to help them actively participate in the member's treatment. One record reviewed showed the Psychiatrist contacting a natural support regarding the member's care. Contact with natural supports is reviewed during program meetings and documented in member calendars and health records.

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

- Team Approach: Consider eliminating primary specialist assignments and adopting a fully shared caseload model to ensure members are seen by multiple staff. Aim for at least 90% of members to have in-person contact with more than one staff within a two-week period, which is consistent with EBP standards. Diversity of staff engaging with members allows members the opportunity to experience unique perspectives and expertise. Additionally, following a *team approach* helps to support staff by potentially reducing burden by sharing the responsibility of member care across the team rather than one singular specialist (H5: Continuity of Staff).
- Co-Occurring Disorders Specialist on the Team: Ensure CODS staff are provided with eight (8) hours of annual training in co-occurring disorders treatment best practices, including appropriate interventions, i.e., the *stage-wise approach* and the evidence-based practice of *harm reduction*.
- Vocational Specialist on the Team: Ensure both vocational staff receive annual training in assisting people diagnosed with a serious mental illness (SMI) to find and retain employment in integrated work settings.
- Full Responsibility of Treatment Services: Integrate all service delivery within the FACT team by ensuring specialists are trained and cross-trained to provide all core ACT functions, including case management, psychiatric services, counseling, employment and rehabilitation services, housing support, and substance use treatment. Reduce reliance on brokered providers, as over 10% of members currently receive housing, employment, or substance use services externally.
- Co-Occurring Disorders Groups: Engage members to participate in group substance use treatment and ensure specialists, not only the CODS, encourage members to consider group treatment. Ideally, 50% or more of applicable members participate in a co-occurring disorders group.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, the team served 70 members and included 11 full-time equivalent (FTE) staff, excluding the Psychiatrist and administrative personnel. The team had a member-to-staff ratio of approximately 7:1. Direct service positions on the team included the CC, two Registered Nurses (Nurse), two CODS staff, one Rehabilitation Specialist, one Employment Specialist, one Housing Specialist, one Independent Living Skills Specialist, one ACT Specialist, and one Peer Support Specialist.	
H2	Team Approach	1 – 5 3	Staff estimated that approximately 100% of members see more than one ACT staff within any two-week period, excluding those members on outreach. The team reported using a geographic zone approach to ensure member contact with eight zones rotated weekly among specialists, excluding the Psychiatrist and CODS staff. Staff are expected to provide services to members within the assigned zone at least once per week. Member contacts are documented on individual calendars and reviewed during program meetings. Staff reported that members are assigned to a "primary" specialist, with approximately seven to ten members per specialist. Primary specialists serve as the main point of contact for members and are responsible for completing	• Ideally, 90% of FACT members have in-person contact with more than one staff in a two-week period. Continue efforts to ensure all members on the FACT roster have in-person contact with more than one team staff every two weeks; a diversity of staff allows members access to the unique perspectives and expertise of staff. • Eliminate 'Primary Specialist' assignment beyond administrative purposes. The team approach of ACT ensures continuity of care for members and creates a supportive environment for staff, potentially reducing the burden of responsibility. FACT staff are cross-trained to work as a transdisciplinary team rather than individual case managers. Further, FACT team staff should collaborate on assessments, treatment planning, and day-to-day interventions.

			administrative tasks (e.g., updating service plans and assessments) and providing in-person services. Based on interviews, staff descriptions of the role varied. Some reported that the primary specialist primarily provides services, while others described a team-based approach in which specialty staff are notified of service needs and engage with the member accordingly. Members interviewed reported typically meeting with two staff per week. Of those two staff, members were most familiar with one. Of 10 randomly selected member records for a one-month period, 80% showed in-person contact with more than one FACT staff within a two-week period.	
H3	Program Meeting	1 – 5 4	Staff reported that the team meets in person five days a week, reviewing all members on the roster Monday, Tuesday, Thursday, and Friday. On Wednesdays, the team meets for an extended session focused on members with higher needs and discusses additional members as time allows. Specialists work five days a week with staggered schedules to ensure weekend coverage. The full team meets on Tuesdays and Thursdays to review all members on the roster. All staff, including the Psychiatrist, are expected to attend program meetings on scheduled workdays. During the observed program meeting, the team reviewed recent and planned member contacts, including those involving members that were hospitalized or incarcerated; completed and	• Broaden the focus of daily program meetings to include active discussion of member progress, barriers, and service outcomes, as well as collaborative problem-solving and person-centered treatment and rehabilitation planning, rather than primarily reviewing staff contacts or schedules. Limiting discussions to scheduling details reduces opportunities to address critical aspects of care, including member needs, progress toward goals, and barriers to engagement. Expanding meeting discussions in this way will likely enhance coordination, support recovery-oriented practices, and allow the opportunity for discussions on how to tailor services to each member's

			planned sessions for members with co-occurring disorders and their stages of change; members on outreach, including the week of outreach and assigned staff for re-engagement efforts; and upcoming appointments. The CC facilitated the meeting by announcing member names from the roster, updating member calendars, and providing clinical guidance to prioritize service delivery. While the full roster was reviewed, discussion focused primarily on staff contacts and time spent with members rather than on visit outcomes, problem-solving, or treatment planning.	circumstances and stage of change, consistent with ACT best practices.
H4	Practicing ACT Leader	1 – 5 4	The CC estimated delivering 5 to 8 hours of direct, in-person services per week, including conducting home visits, providing general and substance use treatment counseling, visiting members in the community while participating in the weekly geographic zone rotation, and providing coverage for team staff as needed. The productivity expectation for in-person service delivery for team staff is 20 hours per week. A productivity report for a recent 30-day period showed the CC delivered 24.3 hours of direct services, approximately 30% of the standard expected of other FACT staff. Of the 10 records reviewed, one reflected that the CC provided in-person services on two occasions during a hospital visit and a hospital discharge staffing.	• Continue the efforts to provide in-person services to members. Optimally, the FACT CC delivers direct services to members at a level equivalent to at least 50% of the expected productivity of other FACT staff.
H5	Continuity of Staffing	1 – 5 5	Based on information provided and confirmed with staff, the team has experienced a turnover rate of approximately 6% since inception in June	

			2024. One ACT Specialist has left the team in the past 16 months.	
H6	Staff Capacity	1 – 5 3	In the past 12 months, the team operated at approximately 79% of its full staffing capacity while still building the team. There are no current vacancies on the team. The CODS position experienced the longest vacancy, with one role unfilled for four months and the other for seven months. Additionally, the Rehabilitation Specialist position was vacant for seven months; the Housing and ACT Specialist positions were each vacant for four months; the Independent Living Skills Specialist position was unfilled for three months; and the Peer Support Specialist position was vacant for two 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 5	The team includes one Psychiatrist that works exclusively with the team on a four-day, 10-hour schedule. Members and staff reported that the Psychiatrist primarily provides in-person services at the clinic once a month, with availability one day per week for community-based appointments. Staff also reported that the Psychiatrist provides services via telehealth (telephone and videoconference) for members that experience barriers to in-person appointments, such as distance. The Psychiatrist is responsible for assessing, diagnosing, and treating FACT members, including providing medication management and consultation with team staff, inpatient providers, and referring providers.	

			Of the 10 records reviewed, six (60%) indicated that members received services from the Psychiatrist once within a 30-day period. Of these encounters, five occurred in the clinic and one was conducted via telehealth. Thirty percent of the records reviewed showed evidence of the Psychiatrist coordinating with inpatient providers or members' natural supports by phone.	
H8	Nurse on Team	1 – 5 5	The team includes two Nurses that work staggered four-day, 10-hour shifts each week. Staff reported that Nurses are readily accessible to the team both in person and by phone and provide services to members in both the community and at the clinic. Nurse responsibilities include administering injections, providing medication education, coordinating with pharmacies, collaborating with primary care and specialty providers, and maintaining communication with inpatient facilities. Records and interviews indicated that Nurses are primarily responsible for visiting members once weekly during hospitalization.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	The team includes two full-time CODS, both with over one year of prior experience providing substance use treatment. Training records indicated that one CODS did not complete any substance use-related training in the past 12 months, while the other CODS completed 3.25 hours. Clinical supervision is provided by the CC, a Licensed Master Social Worker (LMSW), to the CODS staff twice monthly, focusing on performance and substance use treatment	• Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., the *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-

			support. The CC receives monthly supervision from an agency Licensed Clinical Social Worker (LCSW). Staff reported that CODS staff frequently engage in impromptu consultations with the CC and Psychiatrist for guidance on substance use treatment and member care.	occurring disorders model adopted by the team.
H10	Vocational Specialist on Team	1 – 5 3	The team includes two vocational specialists: one Employment Specialist and one Rehabilitation Specialist. Resumes reviewed showed that one vocational staff had over one year of experience supporting individuals to obtain or maintain employment in integrated work settings, and feedback during interviews confirmed that both staff have over one year of prior experience. Training records indicated that neither specialist completed training in the past 12 months related to supporting individuals with SMI in obtaining competitive employment in integrated work settings. Staff reported that vocational staff attend quarterly rehabilitation and employment trainings offered by the RBHA and coordinate member care with the Vocational Rehabilitation Counselor assigned to the clinic.	• 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 12 staff, including the Psychiatrist, and was sufficiently sized to provide adequate member coverage and ensure staff diversity.	
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *Mercy Care FACT Admission Criteria* to screen new referrals and guide determinations regarding eligibility. Staff reported that screenings are conducted by the	

			CC and typically occur in the community. When potential members are incarcerated, screenings may be conducted by phone. During the screening process, the CC informs potential members of the frequency, intensity, and voluntary nature of FACT services. Upon completion, the CC consults with the Psychiatrist, and the Psychiatrist obtains additional information through prescriber-to-prescriber consultations with the member's current clinic. The final admissions decision is made by the Psychiatrist. Referrals are received from a contractor with the RBHA. The CC will assist providers with the RBHA referral process if necessary. Staff reported that there are no circumstances in which the team was pressured to admit members.	
O2	Intake Rate	1 – 5 4	Data provided and reviewed with staff regarding team intakes over the past six months indicated that July, a year past inception, had the highest number of admissions, with nine new members added to the roster. The next highest monthly totals occurred in April and August, with six admissions each.	• Ideally, new intakes into the program do not exceed six (6) each month for a fully staffed team.
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 counseling/psychotherapy and	• Ensure FACT staff coordinate treatment and services delivered to members that receive support from other agency programs. • More than 10% of members reside in settings in which FACT team services are duplicated. The FACT team, to the extent possible, should seek to move members to independent housing units in integrated settings in which all housing support and

			psychiatric services, including medication management. At the time of the review, approximately 18 members (26%) were housed in settings such as behavioral health residential facilities, flex care, transitional re-entry programs, and skilled nursing facilities, where a duplication of ACT services occurs. Per interviews, the team serves 60 members with co-occurring disorders. Of these, eight members (13%) were also receiving services from external providers. Six were in residential substance use treatment facilities, and two were participating in an intensive outpatient program. Staff reported attempts to coordinate with facility staff during weekly visits with members. Of the 27 members engaged in employment and rehabilitative services at the time of review, 21 (78%) were receiving support through the FACT team. Six (22%) were participating in an external Work Adjustment Training (WAT); however, staff reported limited coordination occurs between the team and WAT staff.	case management responsibilities are provided by the FACT team. • Ensure the FACT team fully assumes responsibility for providing members with formal substance use treatment within an integrated team-based model, consistent with the EBP. • Ensure outside providers (Vocational Rehabilitation Services) are aware that in the model of ACT members are to receive all services from within the team, i.e., employment services, and that referral to outside agencies/programs (i.e., WAT) is not in alignment with the EBP of ACT. Ultimately, the FACT team is responsible for upholding the model and providing services that benefit members. • The FACT team and vocational staff may benefit from training or consultation on zero exclusion and the impact and benefits of work. Competitive employment is recognized as a both motivation for and a marker of recovery. An unsuccessful job outcome can be an opportunity to reflect on lessons learned and explore the consequences of personal choices rather than simply a failure or an indication of disability. Ideally, ACT teams are advocating for the member's stated readiness as opposed to steering to paid and unpaid work activities, as this can discourage hope and momentum to active engagement in recovery services.

O4	Responsibility for Crisis Services	1 – 5 5	The team ensures continuous 24-hour crisis support by maintaining two rotating on-call schedules (primary and backup), with one staff designated to each schedule per week. The CC also serves as an additional backup, and staff rotate on-call duties on a weekly basis. Crisis support is provided by phone or in person based on member needs. When members call after hours, staff assess for risk of harm to self or others, first attempting to de-escalate by phone before responding in the community. Following de-escalation, staff collaborate with the member to develop a safety plan. When a member is determined to be a danger to self or others or is under the influence of substances, two staff respond in person for further evaluation. Staff consult with the CC to determine next steps, and when inpatient treatment is indicated, staff transport the member to the hospital and remain with them through admission. Records reviewed showed staff consistently reminding members of the 24/7 availability of the team and providing the *FACT On-Call Card* and/or *Staff Phone List*. Of the members interviewed, all three reported that staff are available after hours. Two stated that staff ensure members have the on-call number, while the third indicated they contact team staff directly when support is needed after hours.	

O5	Responsibility for Hospital Admissions	1 – 5 4	Staff reported that the team is actively involved in most psychiatric hospital admissions. When members experience increased symptoms during business hours, they are brought to the clinic for assessment by the Psychiatrist. When it is determined that a member would benefit from inpatient psychiatric treatment, whether during or after business hours, the team provides transportation to the hospital and remains with the member through the admission, ensuring that inpatient staff receive relevant clinical information. When members lack insight and decline a higher level of care, the team may initiate or assist in the involuntary petition process or request amendments to an existing court order for treatment. A review of data relating to the 10 most recent psychiatric hospital admissions that occurred over a one-month period showed the team was directly involved in 80%. Of the two admissions without team involvement, family members assisted the members with the admissions, and the team was notified afterward.	• ACT teams performing to high fidelity of the model are directly involved in 95% or more of psychiatric admissions. Educate members and their support systems about team availability to support members in their communities or to assist with hospital admissions.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that the team is actively involved in psychiatric hospital discharge planning. Coordination with inpatient staff, including prescriber-to-prescriber consultations, begins at admission, and team staff meet with members within 24 hours. Discharge planning includes scheduling weekly visits and staffings to ensure that a discharge plan is developed within 72 hours of admission. Members are also seen by	

			team Nurses twice weekly while inpatient, and Nurses participate in discharge coordination. FACT staff are present at the time of discharge to assist with transportation, obtaining medications, coordinating program intakes, and ensuring continuity of care. Following discharge, the team conducts daily in-person follow-up for five consecutive days. Members are scheduled to see the Psychiatrist and a Nurse within 72 hours of discharge to support engagement and continuity of medication management. A review of data relating to the 10 most recent psychiatric hospital discharges that occurred over a one-month period showed the team was directly involved in 100%.	
O7	Time-unlimited Services	1 – 5 5	Data provided indicated that zero members have graduated from the team within the past 12 months. Staff reported that one member is expected to graduate from the team within the next 12 months.	
S1	Community-based Services	1 – 5 4	Staff interviewed reported that approximately 80% of in-person contact with members occurs in the community. Of the three members interviewed, two reported most frequently seeing staff in community settings. A review of 10 randomly selected member records showed that staff provided services in the community a median of 79% of the time. Records reflected a range of community-based interventions, including home visits; morning and evening medication observations;	• Optimally, 80% or more of services occur in members' communities. Continue efforts to deliver services to members in their communities, where staff can directly assess needs, monitor progress, model behaviors, and assist members in accessing resources in a natural, non-clinical setting.

			transportation to and from hospital admissions, discharges, and member residences; visits to members during psychiatric and medical hospitalizations; participation in meetings with probation officers; and attendance at staffings for members in treatment and hospital settings.	
S2	No Drop-out Policy	1 – 5 4	Data reviewed with staff indicated that 13 members discontinued services with the team in the past year. Of these, three member deaths, three transfers with team referrals, and one transfer to Arizona Long Term Care were excluded. Of the six remaining discharges, two could not be located, and four were incarcerated at the Department of Corrections. The team retained 93% of the total number of members served in the past 12 months.	• ACT teams ideally retain 95% of the entire caseload yearly. Continue efforts to retain membership in ACT.
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff reported that when members struggle with engagement, the team makes at least four outreach attempts per week for up to eight weeks to support re-engagement. At least two attempts are conducted in the community, while the remaining attempts may occur by phone, email, or other electronic means. The team utilizes an *Outreach Rotation* schedule to identify the type of outreach to be completed each day and the specialist responsible for each attempt. *Outreach Rotation* duties are assigned and rotated daily. Outreach efforts include contacting jails, morgues, hospitals, and natural supports; visiting members' last known addresses and frequented locations; and coordinating with local shelters and shelter staff. Staff also make additional phone contacts to jails, morgues,	

			probation and parole officers, guardians, and area hospitals to support re-engagement efforts. During the observed program meeting, the team discussed six members currently on outreach, noting each member's corresponding outreach week and the staff assigned to daily re-engagement efforts per the *Outreach Rotation* schedule. Of the 10 records reviewed, one showed a lapse in engagement, with no documented attempts to contact for 10 days.	
S4	Intensity of Services	1 – 5 4	Records reviewed indicated that during a 30-day period prior to the fidelity review, the median amount of time the team spent in person with members per week was 89.75 minutes. The highest weekly average for in-person services was 201.75 minutes, while the lowest was zero. Phone and videoconference contact were documented in four records each, with a median of 0.25 contacts per month. The record with the highest frequency of phone contact showed five calls, while the records with the highest frequency of videoconference contact showed eight encounters. Records indicated staff utilized videoconference contact to support members that were incarcerated and conduct virtual medication observations. *The fidelity tool does not accommodate delivery of telehealth services for staff other than the psychiatric prescriber.*	• Continue efforts to provide intensive services to members. FACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. Ensure services are accurately documented.

S5	Frequency of Contact	1 – 5 3	Of the 10 randomly sampled records, FACT staff provided a median of 2.88 in-person contacts per member per week. The highest frequency averaged 8.25 contacts per week, while the lowest was zero weekly contacts. Members interviewed provided varied reports regarding the frequency of staff contact, ranging from one to four times weekly.	• 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.
S6	Work with Support System	1 – 5 4	Data provided indicated that 18 members, 26% of the roster, had identified natural supports. Staff reported that the team provided support to all 18 within the past 30 days. The team aims to contact members' natural supports at least once weekly, with contact typically occurring by phone or in person during home visits. During the observed program meeting, staff discussed recent contact with natural supports for approximately six members (33%) and identified planned contact for seven additional members. The CC encouraged staff to make contact with the natural supports of three more members. Record review showed an average of 2.8 contacts with natural supports over a 30-day period. Of the 10 records reviewed, two included members with identified natural supports. Overall, 40% of records reflected staff contact with members' natural supports. Two records reflected one or two contacts during the month, while two others showed between 11 and 14 contacts.	• 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.

			Based on member calendars provided, 20 unique natural supports were contacted, with most contacts occurring once per month. The number of contacts per member's natural supports ranged from one to nine during the month reviewed. Members interviewed provided varied reports. One member stated that the team contacts their natural support on an as-needed basis; another described collaborating with the team to involve their natural support in treatment planning; and a third indicated having no natural supports.	
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	At the time of the review, 60 members (86%) were identified as having co-occurring disorders. Staff estimated that 45 to 50 members receive weekly structured individual substance use treatment provided by CODS staff or the CC. Treatment sessions occur at least once weekly, are primarily delivered in person in the community or via videoconference for members experiencing incarceration, and range from 25 to 60 minutes in length depending on member needs. A review of member calendars from the previous month showed that 25 members received substance use treatment, ranging from one to five sessions during the month, with the majority (12 members) receiving one session per week. Of the records reviewed, 80% identified members with co-occurring disorders; six of these records showed members receiving individual treatment sessions that ranged from	• 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.

			25 to 90 minutes in length and occurred one to four times monthly. Staff reported that materials used to guide treatment include the *Integrated Dual Disorders Treatment Facilitator Manual* (Hazelden).	
S8	Co-Occurring Disorders Treatment Groups	1 – 5 1	Staff reported that three co-occurring disorder groups, each aligned with a different stage of change, are scheduled three times weekly. Two groups are facilitated by CODS and one by the CC. Per staff interviews, members have not attended any groups in several months, although the team is actively attempting re-engagement. Some staff expressed uncertainty regarding the number of groups currently offered for members with co-occurring disorders.	• Optimally, 50% or more of members with a substance use disorder attend at least one co-occurring disorders treatment group each month. • On FACT teams, all staff participate in engaging members with co-occurring disorders to participate in treatment groups. Ensure specialists, not only the CODS, engage members to consider group treatment.
S9	Co-Occurring Disorders Model	1 – 5 3	Staff reported using a harm reduction approach to support members with co-occurring disorders; however, some staff expressed uncertainty about how the team supports these members beyond referrals to CODS staff. Records reviewed showed evidence of staff, other than the CODS staff and CC, using nonjudgmental, recovery-oriented language to encourage member engagement in co-occurring disorders treatment. During interviews, staff consistently modeled recovery-focused language when discussing members with co-occurring disorders. When medically necessary, staff refer members to detoxification centers or residential and substance use treatment programs. Staff also indicated the team supports member choice and assists members in identifying resources for	• 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. • In addition to documenting *clinical recommendations*, ensure that treatment plans include corresponding goals that reflect each member's individualized

			peer-run community meetings. Staff carry naloxone while in the community, and one record documented staff offering naloxone to a member before the visit concluded. Per interviews, CODS staff implement an integrated, stage-wise approach, assessing each member's stage of change to guide individualized interventions. During the observed program meeting, the stage of change was identified for members with co-occurring disorders, and staff shared whether substance use treatment was provided or scheduled. Specific interventions used to support members outside of formal sessions with CODS staff were not discussed, and some staff lacked familiarity with stage-wise treatment and interventions. Of the eight records reviewed for members with co-occurring disorders, five included treatment plans with goals or interventions addressing substance use; however, one of these records was for a member without a substance use disorder diagnosis. Two plans contained "clinical recommendations": one encouraged the member to meet with qualified staff (CODS or CC) to address harm reduction or addiction, and the other recommended participation in individual substance use counseling. One of these plans also included a measurable treatment goal related to substance use. The remaining record included a plan that was incomplete at the time of review. Treatment plans primarily focused on service frequency and staff assignment rather than on the content	needs. Plans should outline specific team interventions to address substance use within the recovery framework of services provided to support members in moving toward their recovery goals.

			or framework of interventions supporting members' recovery goals. Most staff reported receiving training on the co-occurring disorders treatment model from the CC and through online *Relias* modules. Staff reported no formal opportunities for CODS staff to train the broader team, though informal sharing of guidance and insights occurs.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team includes approximately three staff with lived or living psychiatric experience, including a certified peer staff that fulfills the same responsibilities as other team staff. Staff described the team as diverse, with a range of personal experiences that promote advocacy and support from a peer perspective. One member interviewed reported familiarity with team staff that have lived or living experience and shared that, because of the support and encouragement received, they are completing peer support orientation to obtain certification. Another member shared that hearing team staff with lived or living experience discuss experiences relevant to their own helps them feel understood and supported.	
Total Score:		**113**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1 - 5	5
7. Time-unlimited Services	1 - 5	5
Nature of Services	Rating Range	Score
1. Community-Based Services	1 - 5	4
2. No Drop-out Policy	1 - 5	4
3. Assertive Engagement Mechanisms	1 - 5	5
4. Intensity of Service	1 - 5	4
5. Frequency of Contact	1 - 5	3
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	1
9. Co-occurring Disorders Model	1 - 5	3
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**4.04**	
Highest Possible Score	**5**	