ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

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To: John Hogeboom, Chief Executive Officer

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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 August 4 – 6, 2025, Fidelity Specialists completed a review of the **Community Bridges Inc. - 99th Avenue** 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.

Community Bridges, Inc. operates multiple locations across Arizona, offering a range of integrated mental health services such as medication management, substance use treatment, crisis stabilization, and supportive housing. 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:

- Remote observation of an ACT team program meeting on August 5, 2025.
- Individual videoconference interview with the Clinical Coordinator (CC).
- Individual videoconference interviews with the team Housing, Employment, Peer Support, and ACT Specialists.

- Group videoconference interview with two Co-Occurring Disorders Specialists.
- Individual phone interviews with two (2) members participating in ACT services with the team.
- Closeout discussion with the CC and representatives from 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 Other (Medicare, private, or other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; re-engagement and contact guidelines from the *Mercy Care ACC-RBHA Provider Manual Chapter 400, Mercy Care SMI Behavioral Health Home/Integrated Health Home Operational Manual, Mercy Care FACT/ACT Operational Manual*, and *AHCCCS Policy AMPM 1040*; Community Bridges Inc. ACT Team Policy AZ-SMIFA-01; copies of member calendars; *99ACT Team Contact List*, *Integrated Dual Disorders Treatment (IDDT) Recovery Life Skills Program* manual cover page and orientation packet; co-occurring disorders treatment group sign-in sheets; clinical oversight and training records, and resumes for both 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:

- Nurse on Team: The team includes two full-time Registered Nurses dedicated to serving the 74 members on the ACT roster, ensuring the ability for consistent member coverage.
- Program Size: The team is fully staffed with 12 ACT staff, providing sufficient diversity and coverage for the 74 members served.
- Intake Rate: The team maintains a steady admission rate, which allows staff and members the necessary time and space to support varying levels of onboarding needs. The team accepted a total of two new members during the six months prior to the review.
- Responsibility for Hospital Discharge Planning: The team was involved in 100% of the 10 most recent member psychiatric hospital discharges.
- Individualized Co-Occurring Disorders Treatment: The team has incorporated the provision of formal, individualized substance use treatment to members with co-occurring mental health and substance use disorders.

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

- Responsibility for Hospital Admissions: Address barriers preventing direct team involvement in at least 95% of member psychiatric hospital admissions by identifying factors leading to self-admissions without team support. Educate members and their supports on the availability of the team to provide community-based assistance and facilitate hospital admissions.
- Community-Based Services: Increase the provision of services within members' communities, with an optimal target of 80% or more of contacts occurring in these settings. Records reviewed indicate that staff currently deliver a median of 33% of services in the community. ACT programs demonstrating high fidelity to the model prioritize community-based contacts to facilitate effective status monitoring and the development of functional skills.
- Intensity of Services: Work with staff to increase the average weekly service time delivered to members. ACT teams delivering to the 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 that services attempted and delivered are accurately documented in member medical records.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, the team served 74 members with 11 full-time equivalent (FTE) direct service staff, excluding the prescriber and administrative staff. The team had a member-to-staff ratio of approximately 7:1. Positions on the team included the CC, two Registered Nurses, two Co-Occurring Disorders Specialists (CODS), one Rehabilitation Specialist, one Employment Specialist, one Housing Specialist, one Independent Living Skills Specialist, one Peer Support Specialist, and one ACT Specialist.	
H2	Team Approach	1 - 5 4	Staff reported that at least 95% of members interact with more than one ACT staff within a two-week period. The team employed a geographic zone approach to ensure contact with members, with six zones rotating weekly among specialists, excluding CODS staff and nurses. Contact with members is tracked on member calendars during the daily program meeting. Members interviewed reported interacting with one to four staff each week. Of 10 randomly selected member records reviewed for a one-month period, 70% showed in-person contact with more than one ACT staff within a two-week period.	• Increase contact of diverse staff with members such that 90% have contact with more than one ACT staff 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 the unique perspectives and expertise of staff, as well as the potential to reduce the burden of responsibility of member care on staff.
H3	Program Meeting	1 - 5 5	Staff reported the team meets in person five days per week, reviewing all members on the roster four of those days. All staff, including the	

			prescriber, are expected to attend on scheduled workdays. During the observed program meeting, the team reviewed recent and planned contacts; members' stage of change; missed appointments; outreach efforts; group attendance; engagement with natural supports; hospitalizations; discharge planning efforts; and residential treatment updates, including scheduled staffings. 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 reported delivering 6 to 11 hours of direct in-person services per week, which includes home visits, facilitation of clinic-based groups, being available to members at the clinic, and hospital discharge follow-up in the community. The productivity expectation for in-person service delivery for team staff is 22 hours weekly. A productivity report for a recent 30-day period showed the CC delivered 30.98 hours of direct services, approximately 35% of the standard expected of other ACT staff. Of the 10 records reviewed, one reflected the CC facilitating a budgeting group at the clinic. *This item is dependent on the Provider productivity expectation.*	• Continue efforts to provide in-person services to members. Optimally, the ACT CC delivers direct services to members at a level equivalent to at least 50% of the expected productivity of other ACT staff, with evidence of these services documented in member records.

H5	Continuity of Staffing	1 - 5 4	Based on information provided, six staff left the team in the past 24 months, resulting in a turnover rate of 25%. The Employment and CODS positions experienced the highest amount of turnover.	• If not done so already, attempt to identify factors that contributed to staff turnover or that support retention. Ideally, turnover should be no greater than 20% over a two-year period.
H6	Staff Capacity	1 - 5 4	During the past 12 months, the team operated at approximately 92% of full staffing capacity, with a total of 11 vacancies during this period. The CODS position experienced the longest vacancy, with one role unfilled for five 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 psychiatric prescriber, a Psychiatric Mental Health Nurse Practitioner (PMHNP), that works exclusively with the team on a four-day, 10-hour schedule. Members and staff reported that the PMHNP primarily provides in-person services at the clinic, with community-based or videoconference appointments available for individuals with medical or physical limitations. The PMHNP is accessible to the team via messaging platforms, phone, email, and in person. Sixty percent of records reviewed showed members received in-clinic services from the PMHNP at least once during the one-month period reviewed.	
H8	Nurse on Team	1 - 5 5	The team includes two full-time Registered Nurses (Nurse) dedicated to serving members of the team. The Nurses work staggered schedules, each covering four 10-hour shifts weekly. Nurses are accessible to staff via messaging platforms, phone, email, and in person at the clinic.	

			Reported responsibilities include coordinating care with the PMHNP, administering injections, providing medication education, conducting nursing assessments and hospital visits, and delivering services and medications in both clinic and community settings. Of the 10 records reviewed, 70% showed members receiving nursing services. These services were provided by phone and in the clinic.	
H9	Co-Occurring Disorders Specialist on Team	1 - 5 3	The team includes two full-time CODS staff. One had over one year of experience providing substance use treatment services, while the other had less than one year. Training records indicated that both CODS staff completed 3.5 hours of training related to substance use or co-occurring disorders treatment within the past 12 months. Both received clinical supervision from a Licensed Professional Counselor on a twice-monthly basis.	• ACT teams are staffed with Co-Occurring Disorders Specialists, each with one year or more of experience providing substance use treatment services. • 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' stage of change and the co-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. The Rehabilitation Specialist has been in the role for over one year, while the Employment Specialist joined the team approximately two months prior to the review. A review of the Employment Specialist's resume reflected no prior experience supporting individuals with serious mental illness in	• ACT teams maintain Vocational Specialist staff with at least one year of experience providing employment supports. • 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

			obtaining or maintaining employment in integrated work settings. Training records showed the Rehabilitation Specialist completed three hours of vocational training in the past 12 months, and the Employment Specialist completed 2.5 hours.	members obtain competitive jobs in integrated settings.
H11	Program Size	1 - 5 5	At the time of the review, the team had no vacant positions and was comprised of 12 FTE staff, including the PMHNP. The team is of sufficient size to provide both diversity and coverage to members.	
O1	Explicit Admission Criteria	1 - 5 5	Per interviews, the CC or other trained team staff utilize the *Mercy Care ACT Admission Criteria* and a supplemental questions document to screen new referrals and guide discussions of members' needs. Eligible members must have a serious mental illness (SMI) designation, demonstrate high service needs, e.g., frequent hospitalization, justice involvement, or chronic homelessness, and be willing to participate in services. While staff reported assessing willingness to participate, one member interviewed expressed the belief that ACT services were not voluntary. Referrals are received internally or from external providers, including hospitals and the RBHA. The referral source submits the referral, release of information, and transfer packet from the member's current integrated outpatient behavioral health clinic. Screenings are typically conducted in members' communities or the hospital in which they are currently being treated. If criteria are met, the CC informs the member that the case will be reviewed with the team PMHNP and arranges a prescriber-to-	

			prescriber consultation with the member's current clinic. Upon PMHNP approval, the CC schedules an intake meeting.	
O2	Intake Rate	1 - 5 5	Based on the data provided and reviewed with staff, the team has an appropriate rate of admission. The team has accepted a total of two new members during the past six months.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management, the team provides psychiatric services and medication management, housing support, substance use treatment, and employment/rehabilitative services. The team does not include staff qualified to provide counseling or psychotherapy. Per interviews, one member receives counseling through an external brokered provider.	• 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 with qualifications to provide counseling/psychotherapy to members.
O4	Responsibility for Crisis Services	1 - 5 5	The team reported providing 24-hour crisis support to members through the use of a daily rotating on-call schedule, with each staff assigned one weekday and an additional Wednesday every six weeks; the PMHNP, Nurses, and CODS staff are excluded from the rotation. Crisis support is delivered by phone or in person, as needed. After-hours calls involve assessing for danger to self (DTS), danger to others (DTO), and other at-risk behaviors. When calls are received, staff consult with the CC. When an in-person assessment is required, staff meet with members in the community, complete a risk assessment, and inform the CC of the outcome to determine next steps. De-escalated situations that do not require hospitalization are followed	

			by scheduling the member with the PMHNP as soon as possible. When hospitalization is required, staff transport members to the nearest crisis facility and remain until admission. When members decline assessment by the team PMHNP and/or psychiatric inpatient care, staff initiate a petition for court-ordered treatment or complete an amendment to an existing court order. Members are provided with the *99ACT Team Contact List*, which includes the on-call phone number, team positions, staff assigned to each position, and corresponding phone numbers. Members interviewed reported knowing how to contact the team after hours and having previously utilized the on-call service.	
O5	Responsibility for Hospital Admissions	1 - 5 3	Staff reported active involvement in member hospital admissions. The team engages members in the community to attempt de-escalation when symptoms increase; when stabilization is required, staff coordinate with the CC and, during business hours, the PMHNP. When hospitalization is necessary, staff first seek member consent; if the member lacks insight and is unable or unwilling to provide consent, staff initiate the involuntary petition process. Staff support members throughout the admission process by providing or arranging transportation and coordinating with hospitals, natural supports, and law enforcement to ensure a smooth transition. Per a review of data with staff relating to the 10 most recent psychiatric hospital admissions,	• ACT teams, performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. • Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with opportunities to assess and provide intervention to reduce psychiatric hospitalizations or to assist with admissions when indicated. This may also offer more opportunities for staff to engage and build a rapport with natural supports. • Develop hospitalization plans with members in advance, especially when they have a history of hospitalization without seeking team support.

			which occurred over a two-month time frame, the team was directly involved in 50%. Of the admissions without team involvement, two members self-admitted, two were petitioned for court-ordered evaluation by natural supports or unidentified parties, and one was transported by law enforcement without team knowledge.	
O6	Responsibility for Hospital Discharge Planning	1 - 5 5	Staff reported active participation in discharge planning, including attending weekly staffings with hospital staff, facilitating prescriber-to-prescriber and nurse-to-nurse communication, and collaborating with natural supports. Discharge planning activities involve assessing member readiness, discussions about plans after discharge, coordination regarding member medications, and connecting members to needed supportive services. Team staff are present at all discharges to obtain discharge paperwork and updated medication lists and either facilitate a warm handoff to natural supports or assist with filling prescriptions and providing transportation to planned placements. Following discharge, the team implements a five-day follow-up protocol, including daily in-person contact by a specialist and a PMHNP appointment within 72 hours. Records and member calendars reviewed showed evidence of added support provided to members during this period. Hospital discharge planning and follow-up were discussed during the observed program meeting. Per a review of data with staff relating to the 10 most recent psychiatric hospital discharges,	

			which occurred over a one-month period, the team was directly involved in 100%.	
O7	Time-unlimited Services	1 - 5 5	Data indicated that no members graduated from the team in the past 12 months. Staff estimated that approximately two members would be ready to step down to a lower level of care in the next year.	
S1	Community-based Services	1 - 5 2	Most staff interviewed estimated that 80–95% of in-person contacts with members occur in the community; however, some reported rates as low as 20–30%. Members interviewed provided varied accounts of where services most often occur. One reported seeing staff primarily at the clinic, while another reported most contacts occurred at their home. Members noted visiting the clinic up to four times per month and receiving community-based services once or twice weekly. A review of 10 randomly selected member records showed staff provided services in the community a median of 33% of the time. Members received services through in-person visits conducted during hospitalization, at their homes, while attending court hearings, and within inpatient residential settings. The majority of records reviewed showed member contact occurring at the clinic.	• 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 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 4	According to data provided and reviewed with staff, nine members left the program in the past year. Of those, four could not be located, three moved without a referral, and two transitioned to the Department of Corrections.	• ACT teams ideally retain 95% of the entire caseload yearly. Work to retain membership in ACT. Several factors can impact this number positively, including a clear admission policy, consistency in staffing, natural support involvement,

			The team retained 90% of the total number of members served in the past 12 months.	assertive engagement practices, and taking a recovery perspective and client-centered approach with member care.
S3	Assertive Engagement Mechanisms	1 - 5 4	Staff reported that when members miss appointments or cannot be located, the team makes at least four outreach attempts per week, for up to eight weeks, to reconnect. Two attempts are conducted in the community, and two via electronic means (phone or email). Outreach efforts include visiting members' last known address, checking frequented locations and shelters, and coordinating with shelter staff. The team discusses outreach efforts during daily program meetings and tracks those efforts on member calendars. Additional contacts are made with natural supports, guardians, hospitals, probation officers, jails, and the morgue. During the program meeting observed, staff provided updates regarding completed and planned outreach attempts for approximately five members. Of the 10 records reviewed, four reflected engagement lapses ranging from 9 to 13 days. Reviewers were provided with a copy of the team's contact and re-engagement guidelines from the *Mercy Care SMI Behavioral Health Home/Integrated Health Home* and *Mercy Care DFACT/ACT Operational Manuals*.	• 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 3	Records reviewed indicate that during a 30-day period before the fidelity review, the median amount of time the team spends in person with members per week is 64.75 minutes. The highest weekly average for in-person services was 215.15, while the lowest was 8.75. Some documentation in member records lacked detail of their experience.	• Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Provide individualized support to members, including those that elect not to participate in office-based groups. • Ensure staff are trained in appropriate documentation standards so that services and service time are accurately reflected in member medical records. Some documentation in member records lacks detail of their experience.
S5	Frequency of Contact	1 – 5 2	Of the 10 randomly sampled records, ACT staff provided a median of 2.0 in-person contacts per member per week. The highest frequency averaged 3.5 contacts per week, while the lowest, reflected in two records, averaged 0.25 contacts per week. Phone contact was documented in 80% of records, with a median of 4.5 contacts per month. Two records showed the team provided video conference support up to four times monthly, including participation in staffings with behavioral health residential and hospital inpatient staff. Across all telehealth methods, the combined median duration was 10.38 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• 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 contact should be determined by those needs and immediacy. • Ensure the team is assisting members in working on recovery goals as identified. By using *motivational interviewing* and other techniques, the team can assist members to identify meaningful recovery goals and then offer support and services to members to reach those goals.
S6	Work with Support System	1 - 5	Data provided identified 29 members, 39% of the roster, with natural supports. Of these, staff reported contacting 15 – 20 within the past 30	• Continue efforts to increase contacts with natural supports to an average of four (4) per month for each member with a

		4	days, with an estimated average frequency of once per week. Interactions with members' supports are reviewed during the daily program meetings, tracked on member calendars, and documented in the member records. During the observed program meeting, staff identified the presence or absence of natural supports for each rostered member and confirmed whether an active release of information was in place. Of the 29 members identified with supports, the team discussed recent or planned contact for seven (24%). Member calendars from a recent 30-day period reflected contact with nine (31%) member supports, with staff contacting these supports approximately twice per month. Members interviewed reported that the team does not engage with their natural supports; one member stated they had no supports. Records reviewed reflected an average of 2.0 contacts with natural supports over a 30-day period. Six records documented engagement with supports; of these, three recorded a single contact, while the remainder documented between three and eight contacts.	support system, incorporating these contacts into the natural course of service delivery whenever possible. • Continue to 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.
S7	Individualized Co-Occurring Disorders Treatment	1 - 5 4	At the time of the review, 52 members (70%) were identified as having co-occurring disorders. Staff estimated that up to 11 members (21%) received weekly structured individual substance use treatment from a CODS staff. Sessions were delivered in person, either at the clinic or in the community, and ranged from 30 minutes to two	• Increase the number of members engaged in individualized substance use treatment. • Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders.

			hours, depending on members' needs and the specialist providing the service. During the observed program meeting, staff discussed the engagement of approximately 13 members (25%) with co-occurring disorders in individual or group substance use treatment. Of these, eight members (15%) had recently participated in an individual session or had one scheduled in the near future. Of the records reviewed, five (50%) pertained to members with co-occurring disorders; only one record had documentation of the member receiving individual substance use treatment from CODS staff once during the month period reviewed. Member calendars indicated that 16 members (31%) received at least one individual substance use treatment session during a recent 30-day period.	• Ensure all services delivered are documented in member records. • Consider reviewing documentation of individual treatment during supervision with CODS to ensure it provides sufficient detail and that services align with the member's stage of change.
S8	Co-Occurring Disorders Treatment Groups	1 - 5 3	The team offers two weekly in-person substance use treatment groups at the clinic, facilitated by CODS staff. Per staff interviews, approximately 10 members with co-occurring disorders attend at least one group each month. Member records reviewed did not include documented participation in substance use treatment groups. Group sign-in sheets from a recent 30-day period showed attendance by 13 unique members (25%) with co-occurring disorders. During the observed program meeting, staff discussed approximately eight members that had recently participated in groups or were planning to attend. Member	• Continue 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 groups monthly.

			calendars indicated that six members attended at least one co-occurring disorders treatment group during a recent 30-day period prior to the review.	
S9	Co-Occurring Disorders Model	1 - 5 4	The team utilizes a person-centered approach to supporting members with co-occurring disorders, grounded in models such as Integrated Co-Occurring Disorders Treatment, the stages of change, and harm reduction. Staff reported using the *Integrated Dual Disorders Treatment (IDDT) Recovery Life Skills Program* (Hazelden) manual for both individual and group interventions, referring to this model as "IDDT," which is now more commonly referred to as Integrated Treatment for Co-Occurring Disorders. A stage-wise approach is applied to determine engagement tactics based on where individuals are in their recovery process. Harm reduction strategies utilized by staff included supporting transitions to less harmful substances, educating members on Narcan use and availability, and connecting members to agency Medication for Opioid Use Disorder (MOUD) services. Staff also refer members to detoxification centers, residential or substance use treatment programs, and peer-run community meetings as needed or upon request. During the observed program meeting, staff identified each member's stage of change and used this to guide engagement strategies and interventions, including goal setting, rapport building, and alignment with individual needs.	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as *Integrated Co-Occurring Disorders Treatment*, in the principles of a *stage-wise approach* to interventions, the EBP of *harm reduction,* and *motivational interviewing.* • Ensure treatment plans are written from the member's point of view, are recovery-focused, and reflect individualized goals and needs. Plans should outline team interventions to address substance use while supporting recovery, including supporting members in identifying reduction-of-use goals when a desire for abstinence is expressed.

			Of the five records reviewed for members with co-occurring disorders, three contained treatment plans with recovery-focused substance use goals. Of the other two plans, one had no reference to how the team planned to address substance use and the other included a goal with objectives using traditional language, i.e., abstinence, and required drug screening.	
S10	Role of Consumers on Treatment Team	1 - 5 5	The team includes at least seven staff with personal lived or living psychiatric experience that, when appropriate, share their recovery journey with members. Interviews revealed that at least five of these staff are certified Peer Support Specialists. Staff noted that the high number of peers on the team is distinctive and advantageous, as it allows for firsthand understanding of the member perspective. Members interviewed were not aware of staff on the team with lived or living experience.	
Total Score:		**114**		

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	4
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	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	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	2
2. No Drop-out Policy	1 - 5	4
3. Assertive Engagement Mechanisms	1 - 5	4
4. Intensity of Service	1 - 5	3
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	3
9. Co-occurring Disorders Model	1 - 5	4
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**4.07**	
Highest Possible Score	**5**	