ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

Date: ~~January 30, 2026~~
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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

Between January 12 - 14, 2026, Fidelity Specialists completed a review of the **Community Bridges, Incorporated (CBI), Forensic Assertive Community Treatment (FACT) 2** 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.

CBI operates multiple locations throughout Arizona, providing a comprehensive range of services, including supportive housing, crisis stabilization, ACT, and integrated healthcare. Within Arizona's Central Region, the organization oversees three ACT teams and two FACT teams. 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 a FACT team program meeting on January 13, 2026.

- Individual videoconference interview with the Clinical Coordinator (CC).
- Individual videoconference interviews with the Peer Support, Employment, and Independent Living Skills Specialists.
- Group videoconference interview with two Co-Occurring Disorders Specialists (CODS).
- Phone interviews were conducted with members receiving services from the FACT team; of the five identified, three were successfully reached.
- Closeout discussion with the Director of Serious Mental Illness (SMI) Services, SMI Services Manager and representatives from 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: *FACT Admission Criteria*, SMI Services Re-engagement protocol, member handout, member calendars, copies of cover pages of substance use disorder treatment materials utilized, co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and CODS staff, and the CC's productivity report from a recent four-week 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:

- Small Caseload: The team has an appropriate member-to-staff ratio of 7:1
- Program Size: The team is adequately staffed with ten staff, capable of providing necessary staffing diversity, to the 62 members.
- Responsibility for Hospital Discharge Planning: The FACT team participated in 100% of the 10 most recent psychiatric hospital discharge planning processes.
- Time Unlimited Services: The FACT team provides time-unlimited FACT services to all members. No arbitrary time limits dictate the length of time members receive services. As a result, the team maintains a low graduation rate.

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

- Community-Based Services: Increase delivery of services in members' natural and community-based settings to 80%, where challenges are most likely to occur. Based on records reviewed, staff provided services with a median of 33% of the time in the community.

- Intensity of Service: Increase the average weekly service time delivered to members. FACT teams delivering to fidelity of the model provide members with an average of two (2) or more hours of in-person contact weekly. Records reviewed showed the median amount of time the team spends in-person with members per week is eight (8) minutes.
- Frequency of Contact: Increase support for members receiving infrequent services. FACT teams provide an average of at least four (4) in-person contacts weekly. Records reviewed showed staff provided a median frequency of .38 in-person contacts to members per week.
- Co-Occurring Disorders Treatment Groups: Increase participation of members with substance use disorders in group treatment services, aiming for at least 50% of members with co-occurring disorders attending one or more substance use treatment group session per month. Sign-in sheets for co-occurring disorders group showed low attendance (4%) in a month period.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The FACT team serves 62 members with nine full-time direct service staff, excluding the Psychiatric Mental Health Nurse Practitioner (PMHNP). There was one CC, Rehabilitation Specialist, Employment Specialist, Registered Nurse, ACT Specialist, Independent Living Skills Specialist, Peer Support Specialist and two CODS. The team has a member-to-staff ratio of approximately 7:1.	
H2	Team Approach	1 – 5 3	Staff reported that 40 - 80% of members typically meet with more than one team specialist each week. Staff are assigned to a permanent geographic area (primary zone) for ongoing service delivery. When members require specialty services, staff coordinate and schedule appointments accordingly. In addition to zone-based responsibilities, staff receive daily assignments to ensure member treatment needs are met in a timely and flexible manner. Of 10 randomly selected member records reviewed of a one-month period, 40% of members received in-person contact from more than one staff member from the team within a two-week period.	• Increase contact of diverse staff with members such that 90% have contact with more than one FACT staff every two weeks. FACT team staff are jointly responsible for making sure each member receives the individualized 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 meeting in-person five days a week. Most staff, including the PMHNP, work four 10-hour days and attend program meetings on their scheduled workdays, at least four days per week. During meetings, staff review the full roster, discussing immediate needs, recent contacts and planning interventions. One meeting each week is extended to allow for in-depth discussions and treatment planning. During the observed program meeting, the CC facilitated the meeting, verifying completion of administrative updates, reviewing recent staff contacts, and assigning responsibilities as needed. Staff discussed updates for members about current status on housing, medication, outreach attempts, hospitalizations, and group attendance.	

H4	Practicing ACT Leader	1 – 5 2	The CC joined the team in July 2025. The CC estimated providing approximately four hours of direct in-person services per week. Other staff are expected to provide 22 hours of direct services weekly. Since joining the team, the CC has focused significant effort on training and onboarding new staff. In addition to supervisory and administrative responsibilities, the CC provides direct services to members, including crisis response, walk-in office services, hospital discharge support, and back up coverage. During the program meeting observed the CC reported recent direct contact with members. Based on a review of the productivity report for a four-week period, the CC provided direct services 8% of the expected productivity of other FACT staff. *This item is dependent on the Provider productivity expectation.*	• Optimally, the FACT CC delivers direct services to members which accounts for at least 50% of the expected productivity of other FACT staff. Increase the delivery of in-person member services. Practicing FACT leaders can engage in a range of member care needs including providing counseling/psychotherapy, facilitating or co-facilitating co-occurring disorders treatment groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffings, shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery. • The CC and agency may consider identifying administrative functions not essential to their time that could be performed by the program assistant or other team members.
H5	Continuity of Staffing	1 – 5 3	Based on data provided and reviewed with staff, 14 staff left the team over a two-year period, resulting in 58% turnover. The Registered Nurse position had the highest turnover, with three staff leaving the team during the review period. The Clinical Coordinator, Employment Specialist, Peer Support Specialist, and Housing Specialist positions each experienced turnover twice.	• FACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports the therapeutic relationship between members and staff and promotes team cohesion. The burden of turnover on the team is shared by members since it requires them to repeatedly rebuild trust with service

				providers and to retell their stories, which often include histories of trauma.
H6	Staff Capacity	1 – 5 2	Over the past 12 months, the team operated at approximately 67% of full staffing capacity, with a total of 48 staff vacancies. Significant vacancies were observed across key roles, including the Clinical Coordinator position, which accounted for five months of vacancies. One CODS position was unfilled for ten months, and both Registered Nurse positions remained unfilled for six months.	• Continue efforts to screen potential hires for the responsibilities of FACT services with the goal of operating at 95%, or more, of full staffing annually. • 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.
H7	Psychiatrist on Team	1 – 5 5	The team has one fully dedicated PMHNP. Staff reported that the PMHNP plays a central role in guiding treatment planning, ensuring medication stabilization, and supporting the integration of mental and physical healthcare. The PMHNP meets members in the office, in the community, and via videoconference, with one dedicated day per week for community-based visits. Members that are incarcerated are seen via-videoconference. Members interviewed reported seeing the PMHNP monthly, or more frequent when needed. Three records reviewed showed the PMHNP providing services in the office, at members' homes, and conducting a visit to a member in the hospital.	
H8	Nurse on Team	1 – 5 4	The Registered Nurse joined the team in June 2025. The Registered Nurse provides office and community-based services, including	• Continue efforts to recruit and retain Registered Nurses to ensure consistency of coverage for clinic-based services and

			administering injections, providing medication education, conducting health assessments, coordinating care with physical health providers, supporting hospital transitions, and accompanying members to specialty medical appointments.	community-based services. Having two full-time Registered Nurses is a critical ingredient of a successful FACT program.
H9	Co-Occurring Disorders Specialist on Team	1 – 5 5	The team has two CODS to provide substance use services to 49 members. Training records provided showed both CODS have completed at least four hours of trainings relating to substance use treatment. Both CODS receive clinical supervision from the same Licensed Professional Counselor (LPC) twice per month. One meeting is conducted as group supervision with ACT CODS at the agency. One CODS is a Licensed Master Social Worker and also receives additional weekly in-person supervision as part of licensure requirements.	
H10	Vocational Specialist on Team	1 – 5 2	The team includes two Vocational Specialists. On January 12, 2026, the team Housing Specialist transitioned into the role of Employment Specialist, and a Rehabilitation Specialist joined the team. Per interviews and review of training records, neither had prior experience of assisting individuals find and retain employment in integrated work settings, nor completed training focused on employment or vocational 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 composed of 10 staff, including the PMHNP. There were two vacant positions: one Registered Nurse and the Housing Specialist. The team is of sufficient size to provide the necessary staffing, diversity and coverage.	
O1	Explicit Admission Criteria	1 – 5 4	The team follows the *FACT Admission Criteria* to screen new referrals. The team prioritizes individuals with co-occurring disorders, increased risk of recidivism, or frequent interactions with probation or parole, including some transitioning directly from the Arizona Department of Corrections. The staff uses the *FACT Admission Criteria* tool along with additional questions to gather information about individual service needs, natural support, and provide an overview of FACT services. During meetings, staff discuss the voluntary nature and intensity of services to assess whether the individual is interested in participating in FACT services. Screening may also include staffing with the referring entity, a provider-to-provider call with the PMHNP, and review of medical records. Referrals typically come from Maricopa County Probation, Maricopa County Correctional Health, and Mercy Maricopa Court Services Department. The PMHNP collaborates with staff and will make the final decisions on new admissions. Among recent admissions, staff reported one instance in which the team initially did not recommend admission due to an undesired	• To help maintain control of admission, the agency may want to consider practices to support ACT Leaders. This may include regularly bringing ACT leaders together to share experiences and practices to successfully deny inappropriate referrals.

			intensity of service. Following directives from the RBHA, the individual was admitted but subsequently the member declined services shortly after completing intake.	
O2	Intake Rate	1 – 5 5	According to the data provided and reviewed with staff, 11 new members have been admitted to the FACT team over the past six months. December 2025 had the highest number of admissions, with five new members added to the roster.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services and medication management, counseling/psychotherapy, substance use treatment, and employment/ rehabilitative services. Staff reported that 10 members (16%) reside in housing placements with support services provided by non-FACT staff. Team staff provide weekly home visits, case management, and psychiatric medication management from the team. Additionally, the team holds monthly staffings with service providers to reassess needs and support transition planning. Staff noted that members with felony convictions often face significant barriers to housing, and those with violent offenses in particular may have limited access to general shelters due to safety considerations, highlighting the need for specialized or secure housing options.	• More than 10% of members reside in settings in which services are duplicated. To the extent possible, the FACT team should work to transition members to independent housing units in integrated settings in which all housing support and case management responsibilities are provided by the FACT team.
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported that the FACT team operates 24 hours a day, 365 days a year, ensuring that a team staff is on call every day, including	

			weekends and holidays. Team specialists rotate on-call phone coverage every one to two days, with the CC always available as a backup. Members are provided with a contact list that includes the on-call phone number. When a member calls, staff assess the severity of the situation and conduct a risk assessment to determine the appropriate intervention. In moderate to high-risk situations, after involving the CC, the Clinical Director is consulted to determine whether hospitalization is necessary. Staff may personally transport the member, coordinate with emergency services as needed, and remain with the member until emergency services arrive. Members interviewed reported that team staff are available at any time. Staff will provide transportation to the hospital and actively encourage members to utilize the on-call services offered by the team.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported being involved in about 50% of recent psychiatric hospital admissions. Noting, when members self-admit staff are notified via email. When staff are involved, staff meet members in the community to assess the members' risk level. During business hours, staff consult with the CC and PMHNP. After hours, staff consult with CC and the Clinical Director. If a member is a danger to themselves or others, or is unable to make informed decisions, staff may initiate a court ordered petition for an	• 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. • Increasing member engagement through a higher frequency of contact and intensity of service may provide FACT staff with opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist with

			emergency evaluation. When inpatient care is necessary, staff transport, assist with the admission process, and remain with the member until admission is completed. If emergency services are involved, staff advocate on behalf of the member, coordinate with responders, and will meet or follow the member to the psychiatric unit and provide hospital staff with team contact information and medication lists. Staff conduct hospital visits every 72 hours when appropriate, complete an outreach for coordination of care within 24 hours of notification, and begin discharge planning promptly. Per review of data with staff relating to the ten most recent psychiatric hospital admissions, which occurred over a one-month time frame, the team was directly involved in 40%. In cases of admissions without team involvement, members self-admitted without seeking team support. Staff were not aware of contributing factors prior to member's self-admission.	admissions when indicated. This may also offer more opportunities for staff to engage and build a rapport with natural supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported involvement in 100% of hospital discharges, with discharge planning initiated upon admission. The team conducts staffings with inpatient providers, typically within 72 hours of admission and weekly thereafter. The PMHNP and Registered Nurse consult with hospital providers and staff will visit hospitalized members every 72 hours when clinically appropriate. Discharge planning is coordinated	

			collaboratively with members and when applicable, natural supports or guardians. The team will plan discharge locations, treatment needs, and additional support services. Members are scheduled to be seen by the PMHNP and Registered Nurse within 72 hours of discharge and dates are provided to inpatient teams and the member prior to discharge. Staff are present at the time of discharge to provide a warm handoff, assist with transportation, and obtain discharge paperwork. In cases in which members decline placements and discharge locations are shelter services, staff coordinate medication management, providing limited supplies to reduce risk of loss. The team implements a five-day post-discharge follow-up protocol: staff attempts to meet the member in-person for five days and up to four weeks to monitor care needs and support stabilization in the community. Based on data provided and reviewed with staff, the FACT team was involved in 100% of psychiatric hospital discharge planning that occurred over a four-month period.	

O7	Time-unlimited Services	1 – 5 5	Data showed that one member graduated from the program within the past 12 months, resulting in a graduation rate of 1%. Staff reported that the team is currently monitoring three additional members as potential graduates in the coming year. The team determines readiness for transition to a lower level of care based on indicators such as minimal hospitalizations and contact with law enforcement, successful completion of probation, stable employment, adherence to appointments, and symptomology stabilization. As members continue to demonstrate stability and a reduced need for intensive services, the team collaborates with members to develop individualized step-down and transition plans.	
S1	Community-based Services	1 – 5 2	Staff interviewed reported that 70-80% of in-person contacts with members occurs in the community. Results of 10 randomly selected member records reviewed show staff provided services with a median of 33% of the time in the community. Records showed that four members received community-based services. These services were provided in members' homes and in hospital settings. Services included medication observation and education, medication administration (injections), blood draws, and independent living skills training.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. • Optimally, FACT services are delivered in the community where challenges are more likely to occur. Delivering services in the community offers opportunities for staff to directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting.

S2	No Drop-out Policy	1 – 5 3	According to the data provided and reviewed with staff, 20 members dropped out of the program during the past year. Six member deaths were excluded from this count. The team retained 77% of the members served in the past 12 months. Of those who left the program, two declined services, five could not be located, one left the area without a referral, the team determined three could not be served, and nine were transferred 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, assertive engagement practices, and taking a recovery perspective with a client-centered approach for member care.
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff reported attempting to meet with members up to four times per week. When members are incarcerated, the team schedules weekly video-conference visits. Staff use active listening and provide practical, supportive assistance, such as accompanying members to the bank, providing food boxes, and offering assistance with applications for housing or hotel vouchers for unhoused members, and connecting them to other community resources to engage members in services. When members miss appointments or cannot be located, staff efforts include visiting last known locations, conducting community searches, contacting natural supports or guardians with whom the team has appropriate releases, and checking with probation, jails, hospitals, and the medical examiner's office. Court-ordered service amendments are filed when required. Outreach activities are guided by an eight-week outreach activity guide. During the observed program meeting, staff discussed contacting guardians and natural	• When members are not seen at the frequency indicative of Forensic ACT services, consider starting outreach efforts immediately after an identified lapse in contact. It is essential to discuss and monitor engagement efforts during the program meeting to prioritize team activities. • 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.

			supports; searching for areas members in areas they are known to frequent; checking local jails; and offering services, including counseling, housing assistance, food resources, and meaningful activities. Record review indicated two (2) members were engaged while incarcerated; one received weekly video-conference visits, while the other had one documented contact during the month reviewed. Two (2) additional records showed one documented contact during the month, with no further evidence of outreach or assertive engagement efforts. Additionally, two (2) records showed missed appointments and outreach attempts were not documented until seven days after the missed appointments.	
S4	Intensity of Services	1 – 5 1	Per a review of 10 randomly selected member records, during a month period before the fidelity review, the median amount of time the team spends in-person with members per week is eight (8) minutes. Intensity ranged from 0–66 minutes.	• Increase the duration of services delivered to members. ACT teams provide an average of two (2) or more hours of in-person services per week to help members with serious symptoms maintain and improve functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms. • Consider utilizing existing member calendars to quickly capture a snapshot of who has been seen and who still requires follow-up. Routinely reviewing

				contact data, assessing barriers to in-person service delivery, and incorporating discussions about contact frequency into supervision and team meetings may strengthen coordination of member care and provide oversight. These practices help ensure service intensity and frequency remain aligned with member needs and the ACT model.
S5	Frequency of Contact	1 – 5 1	Of the 10 randomly sampled records, FACT staff provided a median frequency of .38 in-person contacts to members per week. The frequency range was 0-4 contacts a week. Three (3) records reviewed show no in-person contact and two (2) additional records documented videoconference use for those members that were incarcerated. Zero records evidenced phone contact. Members interviewed reported seeing staff 1-2 times per week. *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. • Seek to balance services delivered to more frequently contacted members and those that staff meet with less often. Optimally, members receive an average of four (4) or more in-person contacts a week. • 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. • See recommendation for *S4: Intensity of Services.*

S6	Work with Support System	1 – 5 2	Staff reported that 39 members (63%) have identified a natural support. Staff routinely attempt to contact these natural supports three (3) times per week. When a member cannot be located, staff reach out to their natural supports to assist in finding the member or gathering information. Staff reported that all natural supports are contacted at least once within a 30-day period. These contacts are documented in the electronic health record, and outreach efforts are tracked using a daily-updated calendar from program meetings. During the program meeting observed staff discussed contact with four natural supports. Members interviewed report no team contacts with their natural supports. A review of member calendars showed that the team had contact with 15 natural supports during a recent month period. Most of these contacts occurred once per month, while three natural supports received 2-3 contacts. Of the 10 records reviewed, six were identified as having natural supports. Two records included documented contact with a natural support during the record review period.	• Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four (4) per month for each member with a support system. • Evaluate methods for tracking or monitoring staff documentation of contacts with natural supports. Consider whether discussions about natural support contact during program meetings are also documented on member calendars or other tracking tools already in use.
S7	Individualized Co-Occurring	1 – 5 4	Per staff interviews and data, 49 members were identified with co-occurring disorders. Of these, 68% are receiving in-person, structured individual treatment that integrates care for	• Ensure that members with co-occurring disorders receive individualized, FACT-delivered substance use treatment services to support recovery. Fidelity

	Disorders Treatment		both mental health and substance use disorders. Treatment is tailored to each member's readiness and stage of change and includes evidence-based approaches such as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and Integrated Treatment for Co-Occurring Disorders (ITCOD). Sessions typically occur weekly and last 30–60 minutes. Safety planning is incorporated as needed, and monitoring of substance use treatment is discussed in program meetings and documented in each member's record. Seven of the records reviewed were identified as having co-occurring disorders. One record showed evidence of one 50-minute individualized substance use treatment session.	standards indicate that teams provide an average of 24 minutes or more per week of structured substance use treatment for members with co-occurring disorders. • Monitor member engagement and participation in individual substance use treatment service delivery by the FACT team.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 1	The team offers two weekly co-occurring disorder groups, designed for different stages of change: one for members in the early (contemplation) stage and another for those in the later (maintenance) stage. Staff reported that approximately five members attended the groups at the time of the review. Group sign-in sheets for a recent month showed that two members (4%) identified with a co-occurring disorder attended at least one group during that period.	• Engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring group. • On FACT teams, all staff participate in engaging members with co-occurring disorders diagnosis to participate in treatment groups. Ensure specialists, not only the CODS, engage members to consider group treatment.
S9	Co-Occurring Disorders Model	1 – 5 4	Staff reported using a stage-wise treatment approach, tailoring interventions to each member's stage of recovery or readiness to	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as

			change. Staff approach focuses on harm reduction and reducing use rather than promoting abstinence. Staff help members identify triggers and educate on the relationship between symptoms and substance use. Staff do not refer to peer run substance use programs, however, support members' choice. Prior to members being referred to withdrawal management facilities, members are screened by the PMHNP to determine medical necessity. Team training is a shared responsibility. CODS provide education during morning meetings, sharing new training information as it comes available. In addition, the entire team receives Relias training on ITCOD practices and participates in clinical supervision. Records for seven members identified as having co-occurring disorders showed variability in how treatment plans addressed substance use. Some plans included actionable steps, while others either lacked goals or did not focus on co-occurring disorders. One plan listed *detox and sobriety* as the treatment objective, and another for residential treatment with Peer Support Specialist supports. Four plans did not identify substance use interventions: of these, one focused on increasing social stability and obtaining gainful employment.	*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 incorporate substance use goals that are individualized, written from the member's perspective, and aligned with stage-wise treatment. When members identify abstinence only goals, consider offering an appropriate harm reduction focus as an alternative. Goals reflect the member's readiness for change and plans should outline specific team interventions that support harm reduction, safer use practices, and progress toward recovery. Including substance use goals in treatment plans have the potential to improve consistency and coordination across the team to effectively address members' recovery goals.

S10	Role of Consumers on Treatment Team	1 – 5 5	The team includes a Peer Support Specialist, in addition to other team staff with lived psychiatric experience, that use their personal experiences to support members. The Peer Support Specialist provides practical assistance, such as grocery shopping, organizing, and planning, while explaining tasks in a way that helps members understand and manage challenges. Staff offer support, listening to members' concerns and validating their experiences. One member interviewed was aware of Peer Support services from the team.	
Total Score:		**98**		

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	5
4. Practicing ACT Leader	1 - 5	2
5. Continuity of Staffing	1 - 5	3
6. Staff Capacity	1 - 5	2
7. Psychiatrist on Team	1 - 5	5
8. Nurse on Team	1 - 5	4
9. Co-Occurring Disorders Specialist on Team	1 - 5	5
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	4
2. Intake Rate	1 - 5	5
3. Full Responsibility for Treatment Services	1 - 5	4
4. Responsibility for Crisis Services	1 - 5	5
5. Responsibility for Hospital Admissions	1 - 5	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	3
3. Assertive Engagement Mechanisms	1 - 5	3
4. Intensity of Service	1 - 5	1
5. Frequency of Contact	1 - 5	1
6. Work with Support System	1 - 5	2
7. Individualized Co-Occurring Disorders Treatment	1 - 5	4
8. Co-occurring Disorders Treatment Groups	1 - 5	1
9. Co-occurring Disorders Model	1 - 5	4
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**3.50**	
Highest Possible Score	**5**	