ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

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To: John Hogeboom, Chief Executive Officer

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Introduction

Arizona Health Care Cost Containment System has contracted with the Western Interstate Commission for Higher Education Behavioral Health Program to conduct fidelity reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an Evidence-Based Practice (EBP).

Method

On September 8 – 10, 2025, Fidelity Specialists completed a review of the **Community Bridges, Inc., Mesa Heritage** 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. (CBI) operates multiple locations throughout Arizona, offering a range of services including medication management, substance use treatment, crisis stabilization, supportive housing, ACT services, and integrated healthcare. In Maricopa County, the organization manages three ACT teams and two Forensic ACT (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 an ACT team program meeting on September 9, 2025.
- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with the, Housing, Rehabilitation, Co-Occurring Disorders, and Peer Support Specialists.

- Individual phone interviews with two (2) members participating in ACT services with the team.
- Closeout discussion with the CBI Clinical Coordinator, Director of SMI Services, SMI Services Manager, and representatives from the contractor with a Regional Behavioral Health Agreement (RBHA), and Arizona Health Care Cost Containment System (AHCCCS).
- 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, Long Term Care, Division of Developmental Disabilities, and Other (Medicare, private, other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; *CBI Policy AZ-SMIFA-01;* member calendars; copies of cover pages of substance use disorder treatment materials utilized (*Integrated Dual Disorders Treatment (IDDT) Recovery Life Skills Program* cover page and curriculum orientation); co-occurring disorders treatment group sign-in sheets; individual substance use treatment session report; *MH ACT Special Asst Tracking*; *ACT FACT SUS Clinical Supervision Attendance*; *Clinical Oversight* sessions; resumes and training records for Vocational and Co-Occurring Disorders Specialist staff; *Mesa Heritage ACT Team Phone List; CBI Level of Care Screening*; *Mercy Care ACT Exit Criteria Screening Tool; Step Down Template; SMI Services Reengagement policy;* and productivity report for the Clinical Coordinator for 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:

- Small Caseload: The ACT team serves 86 members with nine full-time direct service staff, excluding the Psychiatric Nurse Practitioner, maintaining a low member-to-staff ratio of approximately 10:1 to support adequate intensity and individualization of services.
- Team Approach: Based on records reviewed, 90% of members were seen by more than one ACT staff within a two-week period.
- Responsibility for Hospital Discharge Planning: The team participated in the discharge planning process for 100% of the 10 most recent member psychiatric hospital discharges.
- Community-based Services: The team showed significant improvement in the delivery of community-based care. A median of 100% of contacts occurred in members' communities demonstrating strong alignment, with an emphasis on community-based support, with the ACT model, rather than traditional office-based services.
- Assertive Engagement Mechanisms: The ACT team demonstrates strong assertive engagement, with frequent attempts of in-person and electronic outreach to members in community settings.

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

- Practicing ACT Leader: The Clinical Coordinator provided direct in-person services 7% of the time in the month prior to the review. Optimally, the ACT Clinical Coordinator provides direct services equal to at least 50% of the productivity expectations of other ACT staff. Consider strategies to increase the Clinical Coordinator's direct service involvement to more closely align with ACT model expectations.
- Continuity of Staffing: The team has experienced a 75% turnover rate during the past two years, disrupting continuity of care and requiring members to repeatedly share their histories, which may include trauma. Reduce turnover and enhance retention efforts to promote workforce stability and ensure more consistent, trauma-informed care for members.
- Frequency of Contact: Increase member contact frequency, aiming for an average of four or more in-person visits per week. Records reviewed indicate a low frequency of services, with a median of 1.38 in-person contacts per member per week. Collaborate as a team to identify and address barriers to achieving this goal.
- Work with Informal Support System: Ensure consistent documentation of interactions with natural supports and implement methods to track and monitor staff documentation of these contacts. Records reviewed showed an average of 0.40 contacts with natural supports over a 30-day period.
- Co-Occurring Disorders Treatment Groups: Sign-in sheets for the co-occurring disorders group in the month prior to the review showed low attendance (11%). Continue to actively offer and engage members with co-occurring disorders in group activities, aiming for at least 50% participation monthly.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 86 members with nine full-time equivalent (FTE) direct service staff excluding the Psychiatric Nurse Practitioner (Prescriber) and administrative staff. The team has a member to staff ratio of 10 to 1. The team consists of a Clinical Coordinator, two Registered Nurses, one Co-Occurring Disorders Specialist, an Employment Specialist, a Rehabilitation Specialist, a Housing Specialist, an Independent Living Skills Specialist, and a Peer Support Specialist. While another Co-Occurring Disorders Specialist is assigned to the team, this individual has been on leave from the position for more than three months and was not credited during this review.	
H2	Team Approach	1 – 5 5	Staff estimated that about half of the members have contact with at least two different staff within a two-week period. Members interviewed consistently reported seeing at least two staff each week. The team follows a zone-based model, dividing the service area into eight zones that are rotated among staff on a weekly basis. Staff schedules are staggered to provide early morning, evening, and weekend coverage, with some staff working until 7:00 p.m. Of 10 randomly selected member records reviewed, for a month period, 90% received in-person contact from more than one staff within a two-week period.	

H3	Program Meeting	1 - 5 4	Staff reported that the team meets in person five days per week to review the full member roster. Specialists work four 10-hour shifts on staggered schedules: Wednesday–Saturday or Sunday–Wednesday. All staff, including the Prescriber, attend on their scheduled workdays, with Wednesdays serving as the primary day for full-team attendance. Due to staggered schedules, some staff may only coordinate in person with certain colleagues once per week. Staff reported staggered schedules can impact the ability to effectively coordinate member care and noted that upon returning from days off, they review emails and team messages to stay current on team updates. During the observed meeting, the Clinical Coordinator facilitated and documented updates in member calendars. Information reviewed included stage of change for members with co-occurring disorders, court-ordered treatment status, last psychiatric appointment, payee involvement, probation, guardianship, and natural supports. Staff present provided updates on most recent contacts, current placements, medication observations, visits with incarcerated members, upcoming appointments, referrals, hospital visits, and participation in substance use treatment groups and individual sessions.	• Evaluate and adjust program staffing practices to ensure consistent full-team participation, including all disciplines. Full attendance will help ensure critical cross-disciplinary information is shared simultaneously, enhancing team communication, member status updates, and coordinated service planning. Consider strategies such as scheduling adjustments or structured handoffs to include staff on staggered schedules.
H4	Practicing ACT Leader	1 – 5 2	The Clinical Coordinator estimated providing 3–5 hours per week of in-person services to members. Staff are expected to maintain 28 hours per week of direct service productivity.	• Increase the delivery of in-person member services. Optimally, the ACT Clinical Coordinator delivers direct services to members which accounts for

			A review of 10 member records showed limited direct service involvement: in one record, the Clinical Coordinator provided two in-person office-based services, while three other records reflected participation in staffings with members via telehealth. According to the August productivity report, the Clinical Coordinator delivered 7.53 hours of direct in-person services and 2.08 hours via telehealth. Based on the productivity report and staff productivity expectations, the Clinical Coordinator accounted for approximately 7% of the expected direct service productivity of the team. *The fidelity tool does not accommodate delivery of telehealth services.* *This item is dependent on the Provider productivity expectation.*	at least 50% of the expected productivity of other ACT staff. • Consider identifying administrative tasks currently performed by the Clinical Coordinator that may be transitioned to other administrative or support staff, if applicable.
H5	Continuity of Staffing	1 - 5 2	Based on information provided and confirmed with staff, the team experienced a 75% turnover rate during the past two years, with 18 staff departures, including staff on leave for three months or more. The Employment Specialist, Rehabilitation Specialist, Co-Occurring Disorders Specialist, ACT Specialist, and Registered Nurse positions were each filled and vacated twice during this timeframe.	• 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. Consistency in staffing contributes to building therapeutic relationships with members and their natural supports, as well as reducing the potential burden on staff. • Continue efforts to recruit and retain experienced staff. Support staff in their specialty roles by ensuring training and

				guidance applicable to the specialty position is provided.
H6	Staff Capacity	1 - 5 3	In the past 12 months, the team operated at approximately 77% of full staffing capacity. The Rehabilitation Specialist position experienced the highest duration of vacancy, remaining unfilled for seven months.	• Continue efforts to screen potential hires for the responsibilities of ACT services with the goal of operating at 95%, or more, of full staffing annually.
H7	Psychiatrist on Team	1 – 5 5	The team includes a psychiatric Prescriber that works four ten-hour days and is readily accessible to the team. Staff reported the Prescriber delivers psychiatric and medication management services to members at least once per month, both in person and via videoconference, including community settings. For videoconference appointments in which the member is in the community, another ACT staff is present to facilitate the session. A review of 10 member records showed that seven members received psychiatric services during the review period. Services to members were delivered in person at the clinic, and via videoconference in which the member was in the community, and to members that were incarcerated via videoconference. Members interviewed confirmed seeing the Prescriber at least monthly, either in their homes or through videoconference.	
H8	Nurse on Team	1 – 5 5	The team has two Registered Nurses that work staggered four 10-hour shifts and rotate coverage for the nurse on-call line. Nurses are available to discuss members' needs with teammates in person, by phone, and through a messaging application. The Nurses coordinate	

			care with the ACT Prescriber and team, provide services in the community and clinic, including medication management, coordination with primary care providers and specialists, follow-up on medical needs, administer injections, medication education, and assessments. Nurses also support members with insulin management and monitor health concerns.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	At the time of the review, two Co-Occurring Disorders Specialists were assigned to the team. One had been on leave for more than three months and was not credited for this item. The other, who has been in the role for over two years, completed five hours of training on best practices in co-occurring treatment within the past 12 months.	• ACT teams are staffed with two Co-Occurring Disorders Specialists for a roster of 100 members, each with one year or more of training/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*. (See *AMPM Policy 930 – Implementation and Fidelity Monitoring of SAMHSA Evidence-Based Practices*.) The Co-Occurring Disorders Specialists 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 4	The team includes two Vocational Specialists. The Employment Specialist has been with the team for over one year. Based on training records provided, the Employment Specialist had not completed recent training specific to supporting individuals with serious mental	• 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. (See *AMPM Policy 930 – Implementation and Fidelity*

			illness in obtaining competitive employment in integrated work settings. The Rehabilitation Specialist joined the team in April 2025, has over one year of experience assisting individuals in obtaining and maintaining employment in integrated work settings, and has completed three hours of related training. Both specialists participate in monthly rehabilitation and employment trainings offered by the RBHA and coordinate member care with the Vocational Rehabilitation Counselor assigned to the clinic.	*Monitoring of SAMHSA Evidence-Based Practices*.) 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 10 direct service staff, which is sufficient to ensure staff diversity and adequate member coverage. There was one vacant ACT Specialist position, and one of the Co-Occurring Disorders Specialists positions was also considered vacant due to the staff being on leave for more than three months.	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported that all specialists conduct screenings, review referral packets, and request release of information documents as needed for individuals referred to the ACT team. Screenings are staffed with the Prescriber, who reviews records and makes the final admission decision. The team reported that there is no pressure to admit members that may not be appropriate for ACT. Admission decisions are guided by *Mercy Care ACT Admission Criteria* and *CBI Policy AZ-SMIFA-01*, which include qualifying psychiatric diagnoses, inability to meet basic needs, lack of success in outpatient care, co-occurring substance use, and frequent law enforcement involvement. Staff also reported that during screening, staff provide education to potential	

			members on the voluntary, intensive, and frequent nature of ACT services.	
O2	Intake Rate	1 – 5 5	Per data provided and reviewed with staff, the team maintains an appropriate rate of admission. April and August had the highest number of admissions in the past six months, with three new members added to the roster each month, which was supported by appropriate staffing levels at the time.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team directly provides psychiatric services, and substance use treatment. The team was not credited for the following services: Housing Support: Based on staff interviews and data provided, the team had 10 members (12%) residing in settings where ACT services are duplicated. Employment/Rehabilitative Services: At the time of the review, staff reported that two members were engaged in competitive employment. The team supports employed members by providing ongoing assistance to help them maintain work, including check-ins, education on benefits, and guidance on balancing employment. Additionally, four to five members were receiving support with job search activities such as resume writing, mock interviews, role-playing, job searching, and attending job fairs. One member was enrolled in a Work Adjustment Training (WAT) program.	*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.* • Continue to monitor the number of members in staffed residences. As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings in which all housing support and case management responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all the services and support from the team. • Ensure vocational service staff receive supervision and training to support directly assisting members to find and keep jobs in integrated work settings rather than relying on vendors. Educate all staff on the benefits of competitive

			Counseling/psychotherapy: The team lacked qualified staff to provide psychotherapy or counseling services. Staff reported that no members have been referred to nor receive these services externally.	employment versus other services (e.g., WAT). • 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 staffing includes a person with qualifications to provide counseling/psychotherapy to members.
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported that the team provides 24/7 crisis coverage through a rotating system. ACT Specialists assigned to the team being reviewed rotate on-call responsibilities weekly, while agency ACT Clinical Coordinators, Psychiatrists, Nurses, and leadership maintain a separate on-call rotation. When a member experiences a crisis after hours, the on-call ACT Specialist first attempts to de-escalate the situation by phone. When further intervention is needed, the on-call agency Clinical Coordinator is contacted to review the circumstances and provide guidance. The agency Clinical Coordinator may then consult with the on-call clinical lead or agency leadership to determine next steps, which can include a field response, risk assessment, additional de-escalation, or transport to a crisis facility or inpatient setting. The team reported that members are educated about crisis resources and are provided with *Mesa Heritage ACT Team Phone List* that includes the on-call number for the team. Members interviewed confirmed awareness of the 24/7 on-call availability of the team and reported using the service in the past.	*Consideration*: Ensure staff have access to clinical support from the ACT team when addressing members' needs after hours, promoting continuity of care instead of relying on rotating agency staff who are not familiar with the ACT members.

O5	Responsibility for Hospital Admissions	1 – 5 3	ACT staff respond to members needing psychiatric stabilization by conducting phone or in-person risk assessments and coordinating with the Prescriber. The Prescriber determines whether the member requires admission to a crisis unit or inpatient facility. When occurring during business hours, staff consult with the Clinical Coordinator and Prescriber to plan the response. When a member requires inpatient psychiatric stabilization, staff coordinate transportation with police, emergency services, or directly by the ACT team, depending on the level of risk, and remain with the member until admission. Staff also ensure coordination with the inpatient team, including nurse-to-nurse and doctor-to-doctor communication, providing information on current medications, and recent psychiatric appointments. Per data reviewed with staff, the team was involved in 40% of psychiatric hospital admissions that occurred over a two-month period. Of the admissions in which the team was not directly involved, two members self-admitted to psychiatric facilities, and four members were taken to crisis units without the team being aware.	• 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 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.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	ACT staff begin discharge planning within 24 hours of inpatient admission and conduct in-person visits to members every 72 hours during hospitalization. The team participates in discharge planning by coordinating placement and addressing basic needs such as food and home stability. Post-discharge, staff provide in-person daily support for five days to monitor	

			medication adherence, daily functioning, and re-acclimation to the community. Members are seen by the ACT Prescriber within three days of discharge, and staff coordinate with the ACT Nurses as needed to address medication changes or other clinical needs. Per data reviewed with staff, the team was involved in psychiatric hospital discharge planning for 100% of the 10 most recent psychiatric hospitalizations that occurred over a three-month time frame.	
O7	Time-unlimited Services	1 – 5 5	Data collected and reviewed with staff showed five members, less than 5% of total served, graduated from the ACT team in the past 12 months. The team uses the *CBI Level of Care Screening* and the *Mercy Care ACT Exit Criteria Screening Tool* to assess members' readiness to step down to a lower level of care. Staff estimated that three members are expected to graduate in the next 12 months.	
S1	Community-based Services	1 – 5 5	Staff reported that 80–90% of in-person contacts with members occur in the community. A review of 10 randomly selected member records showed that staff provided services in the community with a median of 100% of the time. Members interviewed also confirmed that most services are community-based. Documented examples included hospital, shelter, and home visits; while the team provided skill building, medication observation, and transportation (i.e., fast food establishments, grocery stores, and hospitals).	

S2	No Drop-out Policy	1 – 5 4	According to data provided and reviewed with staff, the team had seven members that dropped out of the program in the past year. The team retained 94% 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. 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 and client-centered approach with member care.
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff reported that the ACT team employs multiple strategies to engage members, particularly those that are difficult to reach or do not have consistent phone access. Outreach efforts include contacting natural supports or guardians, visiting members' last known addresses or frequented hangout locations, and checking electronic records such as jail or morgue databases. Staff also check hospitals, community kitchens, shelters, heat relief centers, libraries, and public court records. Outreach occurs approximately four times per week, with two in-person visits and two electronic contacts. Assignments are determined during morning meetings, based on staffing, and consideration of member preferences, such as preferences for male or female staff. A review of records showed that outreach and engagement were documented by multiple staff, sometimes twice per day and up to five consecutive days, including community outreach to locations such as shelters, specific cross streets, and community kitchens. Reviewers were provided with a copy of the *SMI Services Reengagement policy.*	

			Of the 10 records reviewed, one showed two instances of eight days or more of no documented engagement or outreach during the month period reviewed. Phone outreach attempts were also documented for eight members. During the observed program meeting, staff discussed ongoing outreach efforts.	
S4	Intensity of Services	1 – 5 3	Per review of 10 randomly selected member records, during a month period before the fidelity review, the median amount of time the team spent in-person with members per week was 58.88 minutes. The duration of in-person contact ranged from 25.25 -139.25 minutes. Phone contact with members ranged from 2 minutes to 32.75 minutes for seven of the ten records reviewed. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the duration of services delivered to members. ACT teams provide an average of two (2) or more hours of in-person services per week to help members with serious symptoms maintain and improve functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 2	Of the 10 randomly sampled records, ACT staff provided a median of 1.38 in-person contacts per member per week, with a range of 0.75 to 2.50 contacts. Staff reported that members are assigned to ACT staff on a rotating basis and are typically seen one to four times per week, depending on need. Members interviewed reported seeing ACT staff one to two times a week.	• Increase the frequency of contact with members, preferably averaging four (4) or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. • Ensure services are aligned with members' needs utilizing a client-centered approach. Motivational interviewing techniques are useful when assisting members to identify goals. Service plans created alongside members, and updated as needed, should identify

				how the team can support them in reaching their goals.
S6	Work with Support System	1 – 5 2	Based on data reviewed with staff, 75 members (87%) on the team have identified natural supports. The team reviews members' natural supports during program meetings. During the observed program meeting, staff discussed contact with the natural supports of two members. Staff reported that the ACT team aims to contact members' natural supports at least once per week, or four times per month, though actual frequency can vary. Staff estimated that the natural supports of 50–60 members were contacted in the past 30 days. Contact occurs in person or over the phone, and each specialist is responsible for documenting and tracking these interactions. Some members actively involve their natural supports, while others may limit coordination. Staff emphasized that leadership reinforces the importance of including natural supports in planning, as natural supports often provide insight the team may not have. Based on record review, among members identified as having natural supports, contact was documented in four records, each occurring once during the month period reviewed. Members interviewed reported varying experiences: one stated no contact with natural supports, while another confirmed that the team speaks with their natural supports occasionally.	• 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 Disorders Treatment	1 – 5 4	Based on data received and reviewed with staff, 53 members (62%) were identified as having co-occurring disorders. Per staff report, approximately 19 of those members (36%) receive individualized, structured co-occurring disorders treatment. Sessions average 65-70 minutes in length and occur one to two times weekly. Treatment is provided in person, primarily in community settings, with incarcerated members served via videoconference. During the month period reviewed, 26 members received substance use treatment, with an average session length of approximately 47 minutes and an average of approximately one session per month provided by the Co-Occurring Disorders Specialist. Of these members receiving treatment, three members had four or more sessions in a month period. One ACT staff reported incorporating elements of the Cognitive Behavioral Therapy (CBT) model when working with members, focusing on identifying unhelpful thought patterns and developing healthier coping behaviors. This approach was reflected in records for members with and without co-occurring disorders and included, coping skills, relapse prevention strategies, and identifying triggers and emotional responses. Interventions were clearly documented and included coping with anger, practicing deep breathing, meditation practices, physical exercise, journaling, and self-reflection. Material referenced to guide treatment was the	• Continue efforts to increase the number of members engaged in individualized substance use treatment sessions. • Consider indicating the time spent providing individual substance use treatment by the Co-Occurring Disorders Specialist on member calendars.

			Integrated Dual Disorders Treatment (IDDT) Recovery Life Skills Program. Seven member records reviewed were identified as having co-occurring disorders. Of these, one record documented four individual treatment sessions during the month period reviewed by the Co-Occurring Disorders Specialist, with session lengths ranging from 9 to 63 minutes.	
S8	Co-Occurring Disorders Treatment Groups	1 – 5 2	The team offers two clinic-based co-occurring disorders groups weekly, organized by stage of change and using an integrated treatment model: one group for members in pre-contemplation/contemplation and another for those in action/maintenance. One group is facilitated by an ACT staff member without specialized training in treating co-occurring mental health and substance use disorders. Sign-in sheets from the month prior to the review showed that six (11%) unique members with co-occurring disorders attended these groups. Staff reported encouraging members to participate in the groups, which was also reflected in two records reviewed.	• 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. • For co-occurring disorders groups, ACT staff, other than the Co-Occurring Disorders Specialist, can co-facilitate or provide supportive content. The primary facilitator should be clinically trained and provided clinical supervision by an appropriately trained clinician in best practices related to co-occurring disorders.
S9	Co-Occurring Disorders Model	1 – 5 4	Staff reported that members are encouraged to participate in individual substance use treatment sessions and groups. While some staff expressed uncertainty about connections to external supports, such as peer-run substance use programs or detoxification programs, others described actively supporting members to access these resources, including rehabilitation and inpatient treatment when appropriate. Staff emphasized a team approach to using a harm	• 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.*

			reduction framework and motivational interviewing to deliver individualized treatment services, acknowledging relapse as part of the process. Records showed that the seven members identified by the team with co-occurring disorders had individualized substance use treatment goals expressed in members' own voices, such as identifying triggers, and developing coping skills and relapse prevention plans. Examples included members meeting monthly or bi-monthly with the Co-Occurring Disorders Specialist or the Peer Support Specialist. Staff also reported providing education on Naloxone to members and their natural supports, particularly when substance use occurs in shared living spaces. Training in co-occurring disorders, harm reduction, and the stages of change model occur during team meetings, clinical oversight sessions, and through completion of online *Relias* modules. While staff are aligned with harm reduction principles, not all were familiar with how to adjust interventions and interactions with members associated with a stage-wise approach.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team includes at least one staff that shares their lived or living experience of psychiatric recovery with members, including certified peer staff. Staff with lived or living experience were reported to advocate on behalf of members	

			from a peer perspective while fulfilling the same responsibilities as other ACT staff. Members interviewed were familiar with the staff that share personal recovery experiences.	
Total Score:		**110**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1 - 5	5
7. Time-unlimited Services	1 - 5	5
Nature of Services	Rating Range	Score
1. Community-Based Services	1 - 5	5
2. No Drop-out Policy	1 - 5	4
3. Assertive Engagement Mechanisms	1 - 5	5
4. Intensity of Service	1 - 5	3
5. Frequency of Contact	1 - 5	2
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	2
9. Co-occurring Disorders Model	1 - 5	4
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**3.93**	
Highest Possible Score	**5**	