ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

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Introduction

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

Method

On August 4 – 6, 2025, Fidelity Specialists completed a review of the **Terros Health-South Mountain Health Center** 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.

Terros Health offers a comprehensive range of services, including primary care, behavioral health, and substance use treatment. The South Mountain clinic, the focus of this review, was previously operated by Lifewell Behavioral Wellness. The transition began in October 2024, with Lifewell Behavioral Wellness employees fully joining Terros Health by January 2025. Terros Health now operates five ACT teams in Maricopa County. The individuals served through the program are referred to as *clients*, but for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

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

During the fidelity review, reviewers participated in the following:

- Remote observation of an ACT team program meeting on August 6, 2025.
- Individual videoconference interview with the ACT Program Analyst, covering as the temporary ACT Team Supervisor.

- Individual videoconference interviews with the Housing, Employment, and Independent Living Skills Specialists for the team.
- Group videoconference interview with the Co-Occurring Disorders Specialists.
- Individual phone interviews with three (3) members participating in ACT services with the team.
- Closeout discussion with the Terros Health Center Director, ACT Program Analyst, 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, Long Term Care, Division of Developmental Disabilities, and Other (Medicare, private, other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; *8 Week Outreach F/ACT*; copies of Terros Health in-service training attendance roster; member calendars; *South Mountain ACT Team* brochure; cover page of the substance use disorder treatment material utilized *Integrated Dual Disorders Treatment Facilitator Manual* (Hazelden); co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and Co-Occurring Disorders Specialist staff.

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:

- Responsibility for Crisis Services: The team provides 24/7 crisis support, with coverage available by phone and in the community after business hours and on weekends.
- 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, with a median of 96% of contacts occurring in member's communities, demonstrating strong alignment with the emphasis on community-based support rather than office-based in the ACT model.
- Work with Informal Support System: The team increased engagement with members' natural supports since the last review. Contact with natural supports is reviewed during program meetings and is documented in member calendars and health records.
- Individualized Co-Occurring Disorders Treatment: The team increased the provision of formal, individual substance use treatment for members with co-occurring disorders, utilizing an integrated treatment model.
- Co-Occurring Disorders Model: The team applies a stage-wise approach within an integrated model to ensure that member care addresses both behavioral health and substance use needs in a coordinated manner. During program meetings, staff identify each

member's stage of change, and Co-Occurring Disorders Specialists report on interventions tailored to that stage. This practice reinforces staff knowledge and fosters a unified approach to supporting members with co-occurring disorders.

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

- Continuity of Staffing: The team experienced a turnover rate of 84% over the past two years. High staff turnover disrupts consistent care and forces members to repeatedly share their history which may include trauma. Addressing the causes of turnover and strengthening retention strategies can improve workforce stability and support more coordinated, effective care.
- Vocational Specialist on Team: At the time of the review, the team had one full-time Employment Specialist. Maintain two full-time Vocational Specialists to address members' employment interests and needs. Ensure both staff are adequately trained and receive ongoing training to support members in obtaining and retaining competitive employment in integrated settings.
- Intensity of Service: Records reviewed indicate low-intensity service delivery, with a weekly median in-person contact per member of 13 minutes. Provide an average of at least two (2) or more hours of in-person contact per member per week. Evaluate strategies for increasing engagement and enhancing support for members receiving lower-intensity services.
- Frequency of Contact: Records reviewed indicate low frequency of services, with a median of 0.50 weekly in-person contacts per member. Increase the frequency of contact with members, aiming for an average of four (4) or more in-person contacts per week. Collaborate with staff to identify and address barriers to achieving this goal.
- Co-Occurring Disorders Treatment Groups: Sign-in sheets for co-occurring disorders group showed low attendance (10%). Continue to actively engage members with co-occurring disorders to participate in group activities, aiming for at least 50% participation monthly. Assess and address potential barriers that may prevent members from attending groups, such as transportation challenges.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 98 members with 10 full-time equivalent (FTE) direct service staff excluding the psychiatric prescriber (Prescriber) and administrative staff. The team has a member to staff ratio of 10 to 1. The Clinical Coordinator position became vacant one week prior to the review. In the interim, the ACT Program Analyst is providing full-time coverage, with 100% of their FTE dedicated to this ACT team. The team includes the ACT Program Analyst, two Registered Nurses, two Co-Occurring Disorders Specialists, an Employment Specialist, a Housing Specialist, an Independent Living Skills Specialist, a Peer Support Specialist, and an ACT Specialist.	
H2	Team Approach	1 - 5 3	Staff reported that more than two staff typically deliver services to each member per week. The team uses a zone-based approach organized by zip code, with zones rotating daily among staff. There are four zones, and larger zones may be split between two staff to ensure member contact. The team operates on staggered workday schedules, with staff assigned to work weekends. Staff reported completing a daily end-of-shift report which documents the members seen that day, the services provided, and the duration of each service. During interviews, two members reported seeing one to three different staff per week, while	• Ideally, 90% of ACT members have in-person contact with more than one staff in a two-week period. Continue efforts to ensure all members on the ACT roster have in-person contact with more than one staff every two weeks. Staff diversity allows members access to unique perspectives and expertise of staff. Consider confirming attempts and successful contacts are documented in member records.

			another reported going two to four weeks without any staff contact. Of 10 randomly selected member records reviewed over a one-month period, 50% showed evidence of in-person contact from more than one ACT staff within a two-week span. Two of the records showed that members were incarcerated during the review period. Staff maintained weekly video visits via the jail portal. *The fidelity tool does not accommodate delivery of telehealth services.*	
H3	Program Meeting	1 - 5 4	Per staff interviews, the team meets five days a week and reviews all members during each program meeting. Staff are expected to attend on scheduled workdays. The covering agency prescribers do not participate in team program meetings. During the observed meeting, staff identified each member's stage of change, reported recent contacts or updates with natural supports, discussed missed appointments, and shared updates from recent visits. Member calendars are used to document completed contacts, attempted visits, and communication with natural supports as reported by staff.	• Ensure the psychiatric prescriber(s) providing services to ACT members attend the program meeting to support coordination of care among all members, as well as to provide ongoing clinical oversight.
H4	Practicing ACT Leader	1 - 5 2	At the time of the review, the agency ACT Program Analyst was acting as the ACT supervisor, having been in the role for only three days. The Program Analyst is available to the team, including after hours, and serves as a backup for on-call contact for members and staff. The Program Analyst is on-site at the clinic	• Given the importance of the Clinical Coordinator role on the team, ensure that this position is consistently filled by appropriately trained and experienced staff that deliver direct care services to members.

			three days per week and attends program meetings.	• Ensure the covering ACT supervisor provides direct services to members and meets at least 50% of the expected productivity level of other ACT staff while serving in the interim Clinical Coordinator role.
H5	Continuity of Staffing	1 - 5 1	Based on information provided and reviewed with staff, the team experienced a turnover rate of 84% over the past two years. The Registered Nurse position experienced the highest amount of turnover with six staff leaving the position. Members interviewed expressed concern about staff turnover, noting that frequent changes make it difficult to know which staff were on the team.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports the therapeutic relationship between members and staff and promotes team cohesion. • If not done so already, attempt to identify factors that contributed to staff turnover or that support retention. Consistency in staffing contributes to building therapeutic relationships with members and natural supports, as well as reducing the potential burden on staff.
H6	Staff Capacity	1 - 5 4	In the past 12 months, the team operated at approximately 84% of full staffing capacity. The Peer Support Specialist position experienced the highest duration of vacancy, remaining unfilled for five months.	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible with the goal of operating at 95%, or more, of full staffing annually. The timely filling of vacant positions also helps to reduce the potential burden on staff.
H7	Psychiatrist on Team	1 - 5 1	The Prescriber that had been working with the team departed the week before the review. An additional prescriber from the agency was scheduled to transfer to the team within the same month of the review as the designated prescriber. Interim coverage was provided by agency prescribers during the transition.	• Hire a permanent psychiatric prescriber to be assigned to the team full-time to provide services to members. • ACT is designed for members that are typically unsuccessful with traditional case management and require a higher level of service. Ensure ACT members are scheduled to receive intensive and

			A review of 10 randomly selected member records found that 50% had no documented psychiatric services for more than one month prior to the review period, including one member with no documented psychiatric appointments for four months.	flexible services, ideally scheduled with the Prescriber every 30 days or less.
H8	Nurse on Team	1 - 5 5	The team has two Nurses, each working four 10-hour days per week with staggered workday schedules. Each Nurse is assigned one day per week to provide services to members in the community. Both attend the program meeting on scheduled workdays. Nursing responsibilities include monthly member visits, nursing assessments, administering injections, completing medication checks and deliveries, coordinating with pharmacies and medical providers, accompanying members to specialty appointments, and coordinating with hospitals as needed. The Nurses are readily accessible to the team via phone, email, and in person.	
H9	Co-Occurring Disorders Specialist on Team	1 - 5 4	The team has two Co-Occurring Disorders Specialists (CODS). One CODS has served in this role since June 2022 and, according to training records, completed nine hours of training on best practices in co-occurring disorders treatment in the past 12 months. The other CODS joined the team in January 2024 and had not completed training in co-occurring disorders treatment best practices in the past 12 months. Staff reported that the CODS, along with the rest of the team, participate in monthly group supervision on co-occurring disorder treatment provided by a Licensed Associate Counselor.	• Provide eight (8) hours of annual training with CODS in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. The CODS support the team by cross-training staff and guiding interventions based on members' stage of treatment and the team's adopted co-occurring disorders model. • Ensure Co-Occurring Disorders Specialist staff are provided with regular supervision from a qualified professional to support delivery of individual and

				group substance use treatment services in an integrated treatment model approach. Monthly team (group) supervision is likely not sufficient for the needs of this important service delivery.
H10	Vocational Specialist on Team	1 - 5 2	The team has one Vocational Specialist staff, an Employment Specialist that has been with the team for over a year. Based on training records and staff interviews, the specialist has not received training in the past 12 months related to supporting individuals with serious mental illness in obtaining competitive employment in integrated work settings.	• 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. • Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met.
H11	Program Size	1 - 5 5	At the time of the review, the team was comprised of 10 direct service staff, including the temporary coverage of the ACT Program Analyst. The team is of sufficient size to ensure staff diversity and adequate member coverage. There were three vacant positions: Clinical Coordinator, Rehabilitation Specialist, and the Psychiatric Prescriber. *This item does not adjust for the size of the member roster.*	
O1	Explicit Admission Criteria	1 - 5 5	The team uses the *Mercy Care ACT Admission Criteria* screening tool to assess potential members for admission. Screenings prioritize individuals with a qualifying diagnosis that have not been successful in traditional treatment	

			settings and/or demonstrate a high frequency of psychiatric hospitalizations or incarcerations. Referrals are received from other teams within the agency, external provider networks, and the RBHA. Screenings are conducted in person with the potential member, during which staff explain ACT services and what participation entails. The team prefers to involve the referring team in the screening process to provide member history and support a smooth transition when the referral is accepted. The final decision on admission is made by the ACT Supervisor and Prescriber, based on the screening results and the members' agreement to receive ACT-level services. The team reported educating other team leadership on ACT services and criteria for appropriate referrals. When a referred member does not meet criteria, the team either declines the referral or participates in complex case reviews as needed to determine next steps.	
O2	Intake Rate	1 - 5 5	Per data provided and reviewed with staff, the team maintains an appropriate rate of admission. April and July had the highest number of admissions in the past six months, with four new members added to the roster in each month, which was supported by appropriate staffing levels at the time.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management, the team provides housing support, substance use treatment, and employment and rehabilitative services. All members interviewed reported that	• Transfer psychiatric care of all members to a dedicated ACT Prescriber. The EBP of ACT utilizes a team approach for member care. Highly effective programs provide all the service needs of members from within the team.

			the services received are provided exclusively by the ACT team. At the time of the review, members were scheduled with other agency psychiatric prescribers in the interim until a new dedicated prescriber joined the team. The team lacked qualified staff to provide direct psychotherapy or counseling services. Staff reported that no members receive these services externally. One member interviewed shared that they had requested psychotherapy services but had not received any follow-up regarding the referral.	• Make counseling/psychotherapy available to members on the team provided by ACT staff. This staff will also act as generalists within the team. Consider exploring options to provide counseling services to members of the ACT team, either through new or currently existing ACT staff.
O4	Responsibility for Crisis Services	1 - 5 5	Based on interviews, the team provides crisis services to members 24 hours a day, seven days a week. Staff rotate on-call responsibilities weekly, with the ACT Program Analyst serving as the backup. When crisis calls are received by the team, staff use active listening to de-escalate situations over the phone when possible. When needed, staff meet members in the community to assess the situation, consulting with team leadership as appropriate in the decision to hospitalize and transporting members to inpatient services. Members receive a copy of the *South Mountain ACT Team* brochure, which includes clinic contact information and hours, on-call phone numbers, staff names, roles, and contact details, as well as a description of ACT services. Members	

			interviewed were aware of ACT after-hours availability and crisis intervention.	
O5	Responsibility for Hospital Admissions	1 - 5 3	When psychiatric inpatient stabilization is being considered, staff coordinate with the ACT Supervisor and an agency prescriber to assess the need for admission. When it is determined hospitalization is needed, staff then provide transportation to the member and remain at the hospital during the admission process for voluntary admissions. For involuntary admissions, the team may petition for court-ordered treatment or amend an existing order. Based on data provided and reviewed with staff, the team was directly involved in 40% of the 10 most recent psychiatric hospital admissions which occurred over a two-month period. For the remaining admissions, six members self-admitted without prior contact with the team; the team was notified within two days and began discharge planning upon notification.	• 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 in admissions when indicated. This may also offer more opportunities for staff to engage and build a rapport with natural supports. • Consider revisions to member treatment plans to address behaviors and/or circumstances related to not involving the team when admitting to a psychiatric hospital (self-admission).
O6	Responsibility for Hospital Discharge Planning	1 - 5 5	Staff reported that once a member is admitted to an inpatient psychiatric facility, the team coordinates closely with the inpatient treatment team. ACT Nurses will coordinate with inpatient providers, weekly meetings are held, and ACT staff visit the member at least once every 72 hours to support discharge planning. The team actively participates in the discharge process by meeting with the inpatient team and the member, obtaining discharge paperwork, and transporting the member to their discharge destination in the community.	

			The team follows a five-day post-discharge follow-up protocol, which includes in-person contact with the member each day for five consecutive days. Additionally, members are scheduled to see the Prescriber within 72 hours of discharge, followed by a nurse appointment shortly thereafter. Based on data provided and reviewed with staff, the team was directly involved in discharge planning for 100% of the 10 most recent psychiatric hospital discharges over a two-month period.	
O7	Time-unlimited Services	1 - 5 5	Data provided and reviewed with staff showed two (2%) members graduated from the team with significant improvement in the past 12 months.	
S1	Community-based Services	1 - 5 5	Staff interviewed reported that approximately 80% of in-person contacts with members occur in the community. A review of 10 randomly selected member records showed a median of 96% of services were delivered in community settings. Documented community-based services included home visits with specific interventions such as independent living skills training, encouraging participation in group activities, discussing meaningful community-based activities, providing appointment reminders, delivering individual substance use treatment sessions, and medication management and delivery. Members interviewed reported receiving home visits from staff, ranging from once per week to once every three weeks.	

S2	No Drop-out Policy	1 - 5 4	According to data provided and reviewed with staff, 16 members (13%) dropped out of the program in the past year. The team retained 87% of the total number of members served in the past 12 months. Based on data provided and reviewed with staff, two members declined or refused services, five could not be located by the team, five transitioned to a higher level of care, two entered the Department of Corrections, and one left without a referral.	• ACT teams ideally retain 95% of the entire caseload yearly. Work to retain membership in ACT. Several factors can impact this number positively including 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 4	Staff reported following an *8 Week Outreach F/ACT* protocol, making a minimum of four engagement attempts per week for at least eight weeks when contact with a member is lost. ACT staff are assigned specific members to outreach. For members that cannot be located, outreach efforts include visiting the last known address, conducting street outreach in areas the member is known to frequent, checking with the medical examiner's office, hospitals, and jails, and contacting natural supports. Records reviewed showed documentation of outreach efforts such as phone calls to a member and their natural support, attempted home visits, and street outreach. In one record, each entry tracked which day and week the team was on for outreach attempts. Among the 10 records reviewed, three showed gaps of 12 to 17 days with no documented outreach efforts, including in-person or phone engagement attempts.	• When members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Continue to discuss and track these efforts during the program meeting. Consider peer review of documentation to ensure efforts are accurately included in member records.

S4	Intensity of Services	1 - 5 1	Based on a review of 10 randomly selected member records, during a month period before the fidelity review, the median amount of in-person contact per member was approximately 13 minutes. In-person contact time ranged from 0 minutes to a high of 173.75 minutes per week. Phone contact in two member records averaged 1–2 minutes per week, while two records with videoconference contacts (via jail portal) averaged 10–15 minutes per week. *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. • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. Documented service time is significantly higher for some members than for others.
S5	Frequency of Contact	1 – 5 1	Of the 10 randomly sampled member records, ACT staff provided a median of 0.50 weekly in-person contacts per member. The lowest documented frequency was 0 in-person contacts, while the highest was 4.25. Two member records had no documented direct in-person contacts in a 30-day period. The team documented outreach efforts for one member, while the other had phone contact while out of town. In the month period reviewed, alternative contacts included three phone calls, and five videoconference calls.	• 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. • Teams may benefit from routinely reviewing contact data, assessing barriers to in-person service delivery, and integrating discussions of contact frequency into supervision and team meetings. These efforts can help ensure that service intensity remains aligned with member needs and the expectations of the ACT model.

			The fidelity tool does not accommodate delivery of telehealth services.	• *See recommendation for H2: Team Approach.*
S6	Work with Support System	1 - 5 4	Data provided by the team identified 80 members (82%) as having natural supports. Staff reported that while many members are listed as having natural supports, not all are actively involved in treatment and may serve only as emergency contacts. For members with actively involved natural supports, staff report that contact typically occurs weekly and may include phone calls, emails, or in-person conversations during clinic and home visits when members reside with natural supports. Member calendars showed natural support contact for 23 members, ranging from one to six times in one month. During the observed program meeting, staff reported natural support contact for 25% of members with known supports. Members interviewed reported little to no contact between staff and natural supports, with two noting some past interaction during home visits. A review of member records showed an average of 1.10 contacts with natural supports over a 30-day period. Of the 10 records reviewed, eight were for members identified by the team as having natural supports. Among these, three records documented contact with natural supports, with one reflecting six documented contacts within the month period reviewed.	• 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.
S7	Individualized Co-Occurring	1 - 5	Based on data received and reviewed with staff, 80 members (82%) were identified as having co-	• Continue efforts to provide an average of 24 minutes, or more, per week of

	Disorders Treatment	4	occurring disorders. Per staff reports and data provided, 61 members (76%) receive individualized, structured co-occurring disorders treatment, averaging 24 – 30 minutes in length. Treatment is provided in person, primarily in community settings, with incarcerated members served via videoconference, as seen in records reviewed. Member calendars for a recent month show that individual co-occurring disorders treatment averaged approximately 10 minutes per week across all members identified with co-occurring disorders. Of these 15 members (25%) received four or more sessions in that month. A review of six member records showed that three members received at least weekly individualized sessions averaging 20 to 29 minutes, while the other three records contained documentation of CODS attempts to engage. Materials referenced to guide treatment include *Integrated Dual Disorders Treatment Facilitator Manual* (Hazelden), and another manual not specific to co-occurring disorders treatment.	structured individualized substance use treatment services for all members with co-occurring disorders.
S8	Co-Occurring Disorders Treatment Groups	1 - 5 2	The team offers two co-occurring disorders treatment groups each week, facilitated by the CODS using an integrated treatment model. Sign-in sheets from the month prior to the review indicated that eight (10%) unique members with co-occurring disorders attended these groups. The sign-in sheets also included members not identified by the team as having co-occurring	• Continue to engage members to participate in group substance use treatment, as appropriate, based on stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring group. • Consider adapting one group for members in earlier stages and one group for members in later stages, allowing staff

			disorders. Staff reported these members attend groups when the topics resonate with personal experiences and are not limited to substance use only. Staff also indicated that transportation is a barrier to consistent participation in groups.	to adjust interventions to better serve members in various stages of change.
S9	Co-Occurring Disorders Model	1 - 5 5	Staff interviewed reported that the team uses a harm reduction approach to support members with co-occurring disorders. During interviews and the program meeting, staff modeled language that was focused on recovery. This language was also evident in records reviewed. Staff refer members to detoxification programs when medically necessary and assist those seeking peer-run substance use programs. During the program meeting, staff reported each member's stage of change, and CODS staff referenced specific interventions used in sessions. Staff reported receiving online training through *Relias*, and monthly supervision. Staff noted that hearing CODS staff discuss interventions applied with members during daily meetings help educate the team and align service delivery in an integrated treatment model approach. Of the six records reviewed for members with co-occurring disorders, five treatment plans identified interventions describing how the team would support the member in moving toward recovery goals. In one record, no recent substance use treatment goals were identified	

			during a time which the member was on outreach.	
S10	Role of Consumers on Treatment Team	1 - 5 5	Interviews indicated that at least three staff on the team have lived or living psychiatric experience. The team has one certified Peer Support Specialist. Staff with lived experience were reported to advocate on behalf of members from a peer perspective while fulfilling the same responsibilities as other ACT team staff. One member interviewed described the benefit of having an ACT staff sharing personal recovery experiences, stating it helps the member feel understood and better supported by the team.	
Total Score:		**103**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score
1. Small Caseload	1 - 5	5
2. Team Approach	1 - 5	3
3. Program Meeting	1 - 5	4
4. Practicing ACT Leader	1 - 5	2
5. Continuity of Staffing	1 - 5	1
6. Staff Capacity	1 - 5	4
7. Psychiatrist on Team	1 - 5	1
8. Nurse on Team	1 - 5	5
9. Co-Occurring Disorders Specialist on Team	1 - 5	4
10. Vocational Specialist on Team	1 - 5	2
11. Program Size	1 - 5	5
Organizational Boundaries	Rating Range	Score
1. Explicit Admission Criteria	1 - 5	5
2. Intake Rate	1 - 5	5
3. Full Responsibility for Treatment Services	1 - 5	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	5
2. No Drop-out Policy	1 - 5	4
3. Assertive Engagement Mechanisms	1 - 5	4
4. Intensity of Service	1 - 5	1
5. Frequency of Contact	1 - 5	1
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	2
9. Co-occurring Disorders Model	1 - 5	5
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**3.68**	
Highest Possible Score	**5**	