

## 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**

Between April 20 and 22, 2026, Fidelity Specialists completed a review of the **Terros Health – 51<sup>st</sup> Avenue** ACT team. This review is intended to provide specific feedback on the development of your agency's ACT services in an effort to improve the overall quality of behavioral health services in Maricopa County.

Terros Health was founded in 1969 and has since operated multiple health centers across Arizona. Care provided by Terros Health ranges from primary care to integrated behavioral health services. Terros Health now operates five ACT teams, including the team located at the 51<sup>st</sup> Avenue location. The individuals served through the program are referred to as *members*.

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 April 21, 2026.
- Individual videoconference interview with the Clinical Coordinator.

- Individual videoconference interviews with Co-Occurring Disorders, Housing, Vocational (Employment), ACT, and Peer Support Specialists for the team.
- Individual phone interviews were conducted with members receiving services from the ACT team; of the five identified, four were successfully reached.
- Closeout discussion with the Clinical Coordinator, and representatives from the Arizona Health Care Cost Containment System (AHCCCS) and the contractor with a Regional Behavioral Health Agreement (RBHA).
- Charts were reviewed for 10 randomly selected members using the agency's electronic health records system. The sample included members from the following health plans: RBHA and Other (Medicare, private, or other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria* form; Terros Health outreach policies and *Mercy Care ACT Outreach and Engagement Guidelines*; member calendars; copies of cover pages of substance use disorder treatment materials utilized; co-occurring disorders treatment group sign-in sheets; and 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 three 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 Hospital Discharge Planning: Since previously being reviewed, the team has improved in this area. Per the data provided and evidence within member records, the team was involved in 100% of hospital discharges to ensure continuity of care for members.
- Community-based Services: A median of 80% of services were provided by staff to members within the community.
- Work with Support System: The team had a high level of engagement with the support systems of members such as offering resources to natural supports (e.g., family counseling and food boxes).

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

- Practicing ACT Leader: Continue to create capacity, such as transferring administrative responsibilities to other staff, to allow for the Clinical Coordinator to provide at least 50% of the expected productivity of other ACT staff. Also, ensure that productivity expectations for the ACT team are attainable.

- Vocational Specialist on Team: Ensure all Vocational Specialist staff have at least four (4) hours of annual training focused on supporting members in competitive employment in integrated settings. Per the review of training records both Vocational Specialists had less than four hours of relevant vocational training.
- Co-Occurring Disorders Treatment Groups: Continue having all staff encourage members to consider engagement in co-occurring substance use treatment services so that at least 50% or more of applicable members participate in co-occurring disorders groups monthly. At the time of the review, there were 15 (26%) unique members with co-occurring disorders that attended at least one co-occurring disorders treatment group.

**ACT FIDELITY SCALE**

<b>Item #</b>	<b>Item</b>	<b>Rating</b>	<b>Rating Rationale</b>	<b>Recommendations</b>
H1	Small Caseload	1 – 5 5	<p>The team is comprised of 11 full-time direct service staff, excluding the assigned psychiatric provider (Prescriber) and administrative staff, to serve 98 members. The member-to-staff ratio at the time of the review was approximately 9:1.</p> <p>The team includes a Clinical Coordinator, two Co-Occurring Disorders Specialists, a Peer Support Specialist, an Employment Specialist, a Rehabilitation Specialist, two Registered Nurses, a Housing Specialist, an Independent Living Specialist, and an ACT Specialist.</p>	
H2	Team Approach	1 – 5 5	<p>Staff reported that most members see more than one ACT staff in a two-week period. Staff reported seeing most members on the roster and that schedules are rotated to work with different members. The team uses a report generated from the electronic health record to determine which members need additional visits for the week.</p> <p>Staff reported having assigned caseloads and are responsible for updating treatment plans and coordinating meetings with outside providers, e.g., inpatient staff when hospitalized.</p>	

			<p>All four members interviewed reported seeing more than one staff in a two-week period.</p> <p>Of 10 randomly selected member records reviewed, for a month period, 100% of members received in-person contact from more than one staff from the team in a two-week period.</p>	
H3	Program Meeting	1 – 5 5	<p>The team meets four days a week to review all ACT members. All staff attend, and the Prescriber attends at least one to two times a week, staying for the entire meeting.</p> <p>During the observed meeting, the Clinical Coordinator facilitated the meeting and guided next steps for member care. The team discussed the members' current stage of change regarding co-occurring disorders, recent and upcoming appointments, hospitalizations, jail visits, coordination of care with specialty providers, and contact with the natural supports. All members on the roster were reviewed during the meeting.</p>	
H4	Practicing ACT Leader	1 – 5 4	<p>The Clinical Coordinator has held this position since 2021. Staff reported that the Clinical Coordinator provides direct services such as conducting home visits with members that the team has had difficulty engaging, medication observations, and attending Prescriber appointments with the member. Staff estimated that the Clinical Coordinator provides approximately 30-40% of direct services. The productivity expectation provided was over 60 hours a week for staff and 30 hours for the Clinical Coordinator.</p>	<ul style="list-style-type: none"> <li>Continue efforts to provide in-person services to members by ensuring the ACT Clinical Coordinator delivers direct services at a level equivalent to at least 50% of the expected productivity of other ACT staff. Reassign non-essential administrative functions to the program assistant or other team staff so the Clinical Coordinator can prioritize direct service delivery, documentation, and</li> </ul>

			<p>Per the productivity report provided, the Clinical Coordinator provided approximately 40 hours of direct services in a 30-day period.</p> <p>In the ten records reviewed, the Clinical Coordinator was documented providing direct services in three records, including attending Prescriber and specialist appointments, providing independent living skills training, assessing home safety, and participating in hospitalization discharge planning meetings via videoconference.</p> <p><i>The fidelity tool does not accommodate delivery of telehealth services.</i> <i>This item is dependent on the Provider productivity expectation.</i></p>	<p>modeling effective clinical interventions that support member outcomes.</p> <ul style="list-style-type: none"> <li>• Create achievable productivity expectations for ACT staff and Team Leads, to potentially prevent burnout.</li> </ul>
H5	Continuity of Staffing	1 – 5 5	Based on information provided, and reviewed with staff, the team has experienced a turnover of 17% during the past two years. The team had four staff leave in the past two years, including a Rehabilitative Specialist, Psychiatrist, Registered Nurse, and Housing Specialist.	
H6	Staff Capacity	1 – 5 5	In the past 12 months, the team has operated at approximately 99% of its full staffing capacity. The position with the most vacancies was the Rehabilitative Specialist that was vacant for two months.	
H7	Psychiatrist on Team	1 – 5 5	The Prescriber for the team was a Board Certified Psychiatric Mental Health Nurse Practitioner that has been serving the team since March 2025. Staff reported that the Prescriber assists in deciding ACT eligibility for new members, coordination with inpatient hospital	

			<p>staff, prescribing psychiatric medications, and meeting members monthly for psychiatric appointments. The Prescriber meets with members in the office, community, and via telehealth if needed.</p> <p>The Prescriber works Monday through Thursday, 40 hours a week. Staff reported having easy access to the Prescriber during business hours and after hours by group messaging, phone calls, and in-person contact.</p> <p>The Prescriber was observed providing psychiatric services in 90% of the records reviewed. The one record in which the member was not seen, documentation indicated that the member cancelled the appointment. Two treatment plans identified goals of seeing the Prescriber every 60-90 days, despite there being evidence from records of the members being seen monthly by the Prescriber.</p>	
H8	Nurse on Team	1 – 5 5	<p>At the time of the review, the team had two Registered Nurses that were scheduled with the team, 40 hours a week for four workdays. The Registered Nurses work with members in the office and in the community providing injections, blood draws, hospital visits, coordinating and attending primary care and specialist appointments with members, and conducting health assessments. Both Registered Nurses attend at least two program meetings a week and are accessible to the team by group messaging, phone call or text messaging, and in-person. It was unclear whether the Registered Nurses were accessible after business hours.</p>	

			One of the Registered Nurses also functions as the Lead Registered Nurse for the clinic, supervising other nurses and medical assistants. Staff estimated that these responsibilities take up approximately 5% of one Registered Nurse's time.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 4	<p>The team had two Co-Occurring Disorders Specialists, including one that has been in the role since 2016 and the other since 2017. Based on training records, one specialist had over four hours of training, while the other had only one hour of relevant training related to substance use treatment in the past year.</p> <p>Staff reported receiving weekly group supervision that includes discussion of co-occurring disorders best practices, by the Clinical Director, a Licensed Master Social Worker. No staff with clinical credentials were identified as providing individual or group supervision to the Co-Occurring Disorders Specialists.</p>	<ul style="list-style-type: none"> <li>• Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., <i>stage-wise approach</i> and the evidence-based practice of <i>harm reduction</i>. (See <i>AMPM Policy 930 – Implementation and Fidelity Monitoring of SAMHSA Evidence-Based Practices</i>.) The CODS support the team by cross-training staff and guiding interventions based on the members' stage of change and the co-occurring disorders model adopted by the team.</li> <li>• 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.</li> </ul>
H10	Vocational Specialist on Team	1 – 5 3	The team has two vocational staff; an Employment Specialist that has been serving the team since 2016 and a Rehabilitative Specialist that recently joined the team in February 2026. Resumes of both staff confirmed several years of experience supporting individuals in competitive employment in integrated settings. Neither staff	<ul style="list-style-type: none"> <li>• 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</li> </ul>

			had four or more hours of vocational training in the past year. The Employment Specialist attends quarterly coordination meetings with vocational rehabilitation services.	members obtain competitive jobs in integrated settings.
H11	Program Size	1 – 5 5	At the time of the review the team was composed of 12 staff, including the Prescriber, and had no vacant positions.	
O1	Explicit Admission Criteria	1 – 5 5	<p>Reviewers were provided with the <i>Mercy Care ACT Admission Criteria</i> form that staff reported utilizing to screen members for appropriateness for ACT services. Using these criteria, the Clinical Coordinator and both Co-Occurring Disorders Specialists conduct screenings with potential members. During screenings, staff explain the frequency, intensity, and voluntary nature of ACT services to potential members. If members agree to these services, then staff move forward with the screening process. When members meet criteria, then the team will meet with the Prescriber to make the final admission decision.</p> <p>Referrals for ACT services are often received from agency supportive level teams or walk-ins at the clinic, which staff will coordinate with the assigned case manager of the member for referral. ACT staff recruit members within the agency by participating in supportive level team meetings and presenting information about ACT services during all-site meetings. Staff reported not experiencing recent pressure to admit members to the team.</p>	
O2	Intake Rate	1 – 5 5	Based on the data provided and reviewed with staff, the team had an appropriate monthly rate of admission with five members joining the team	

			in the six months leading up to the review. The highest monthly admission was two new members. The team was adequately staffed to have the capacity to support new member admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 4	<p>In addition to case management, the team provides psychiatric services and medication management, substance use treatment, and employment/rehabilitative services.</p> <p>The team was not credited for providing the following services:</p> <p>Housing support – Staff reported that approximately twelve members (12%) resided in settings with on-site supportive or therapeutic case management services such as group housing, residential facilities, recovery homes, assisted living, and 16-hour flex-care settings. Staff reported coordinating with residential services with weekly meetings and coordinating with staff regarding member’s medications.</p> <p>Counseling/psychotherapy – At the time of the review, there were no licensed staff on the team to provide therapeutic counseling services to ACT members. Staff reported that three members were referred off the team to outside counseling services.</p>	<p><i>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.</i></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Make counseling/psychotherapy available to members on the team provided by ACT staff. This staff will also act as a generalist within the team. Consider exploring options to provide counseling services to members of the ACT team, either through new or currently existing ACT staff.</li> </ul>

O4	Responsibility for Crisis Services	1 – 5 5	<p>Staff reported providing crisis services and support to members 24 hours, seven days a week. Staff rotate the on-call responsibility weekly and provide support to members after business hours and on weekends. Members are provided with a handout of ACT staff and ACT on-call numbers, and staff also help program these numbers into the phones of members. When members call the crisis line, they are connected to on-call or back-up ACT staff. Staff are responsible for talking to the member on the phone and responding in-person if additional support is needed by the member. Staff reported that when members call outside crisis lines, the providers are aware that the member is part of an ACT team and the member will be re-directed to their ACT team for crisis services. Two of the four members interviewed reported they would contact staff after-hours or on the weekend if in need of immediate assistance or someone to talk to.</p>	
O5	Responsibility for Hospital Admissions	1 – 5 4	<p>When members are in crisis or not at their usual baseline, staff will attempt to de-escalate the member either over the phone or in person, or get the member scheduled to see the Prescriber as soon as possible. If de-escalation over the phone is not enough then staff will assess the member in-person and transport the member directly to the hospital when the member poses an immediate risk to themselves or others. When the member is showing signs of decompensation the team will consult with the Prescriber to determine whether to admit the member to the hospital. Staff will wait with the member and assist them through the hospital</p>	<ul style="list-style-type: none"> <li>ACT teams performing to high fidelity of the model are directly involved in 95% or more of psychiatric admissions. Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members, and their supports, on how the team can provide aid prior to and during admission, especially for members with a history of seeking hospitalization without team support.</li> </ul>

			<p>intake. For involuntary hospitalizations, staff will utilize the petition process as needed.</p> <p>Per review of data with staff and member records relating to the ten most recent psychiatric hospital admissions, which occurred over a three-month period, the team was directly involved in 70% of admissions. For admissions in which the team was not involved, members self-admitted, or the member's family transported the member to the hospital without contacting the ACT team. Two of the records reviewed had documentation of recent hospitalizations, and one of these records had evidence of the team transporting the member to the hospital, waiting with the member through intake, and coordinating and providing background information on the member to inpatient staff.</p>	<ul style="list-style-type: none"> <li>• Provide contact information to the natural supports of members in the event of the member requiring support and assistance in the community to facilitate team involvement.</li> </ul>
O6	Responsibility for Hospital Discharge Planning	1 - 5 5	<p>Once members are hospitalized, staff reported visiting the member in the hospital and meeting with inpatient staff every few days, including coordination between the Registered Nurses, Prescriber, and other inpatient hospital staff. During these meetings, staff reported advocating on behalf of members, providing information regarding member's baseline functioning, and ensuring the member has a safe place to go upon discharge and is ready to discharge. Once a member is scheduled for discharge, ACT staff will pick up medications and set-up transport from the hospital with either staff picking up members or communicating with natural supports that will transport the member. Staff</p>	

			<p>reported following a five-day in-person follow-up protocol with members that have recently been discharged. This includes staff visiting the member for five consecutive days to ensure the member is taking their medications and is stable post-hospitalization. Members are also scheduled to follow up with the Prescriber and their primary care providers within one week of discharge.</p> <p>Per the review of data with staff relating to the last ten psychiatric hospital discharges, the team was directly involved in 100%.</p> <p>Two records reviewed had evidence of the staff either transporting the member directly from the hospital to the clinic following discharge or coordinating with the natural support of the member to transport. Both records also had documentation of staff providing or attempting in-person five-day follow-up visits after hospitalization, including scheduling appointments with the Prescriber within seven days.</p>	
O7	Time-unlimited Services	1 – 5 5	Per the data provided and reviewed with staff, approximately 2% of members graduated from the ACT program. Staff reported that approximately 5% of members are expecting to graduate from the team in the next 12 months.	
S1	Community-based Services	1 – 5 5	Staff interviewed reported that 75%-90% 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 80% of the time in the	

			community. Documented community contacts included staff transporting members to the hospital, visiting members while inpatient, medication observations, psychiatric appointments within the member's residence, supporting members at specialist appointments, conducting home environment assessments, and individual substance use treatment sessions. Members reported seeing ACT staff most often in the clinic, however; all members reported staff visiting them in the community at least once a week.	
S2	No Drop-out Policy	1 – 5 5	<p>According to data provided and reviewed with staff, the team had two members that were justice-involved and dropped out of the program in the past year. The team retained 98% of the total number of members served in the past 12 months.</p> <p>The team had two member deaths in the past year.</p>	
S3	Assertive Engagement Mechanisms	1 – 5 5	Reviewers were provided with the agency outreach policies and <i>Mercy Care ACT Outreach and Engagement Guidelines</i> . Per the guidelines and staff report, when the ACT team is unable to engage a member, the team will make four outreach attempts a week, including within the community, for up to 8 weeks before members are transitioned to a lower level of care. Staff reported the following strategies to locate and re-engage members: coordinating with payees to have members pick up checks at the clinic, street outreach to shelters or where members are known to frequent, and communication with the member's known natural supports. Staff	

			<p>reported offering members bus passes and other resources, and continuing to support and connect with members to build trust to keep them engaged in services.</p> <p>In the records reviewed, there was documentation of ACT staff conducting home visits, calling hospitals, and contacting natural supports to locate members to re-engage in services. The longest duration of no documented contact or outreach to members was for 5 days in the records reviewed.</p>	
S4	Intensity of Services	1 – 5 4	<p>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 approximately 101 minutes. Average weekly direct services ranged from approximately 54 to 215 minutes.</p> <p>The maximum intensity of alternative contact methods, including phone and videoconference, was approximately 25 minutes. Phone contact was observed in two records and videoconference in three records.</p> <p><i>The fidelity tool does not accommodate delivery of telehealth services.</i></p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
S5	Frequency of Contact	1 – 5 4	<p>Of the 10 randomly sampled records, ACT staff provided a median frequency of 3.38 in-person contacts to members per week.</p> <p>Phone and videoconference weekly average frequencies ranged from 0.25 to 3 times a week.</p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>

S6	Work with Support System	1 – 5 5	<p>Per the data provided and reviewed with staff, 57% of members have identified natural supports. Staff reported engaging with up to approximately 54% of natural supports of members weekly in the past 30 days. Engagement with natural supports was reported occurring most often in the community when staff visit members at their home. Staff reported offering resources to natural supports such as family counseling, peer support, food boxes, and assisting them in filling out administrative paperwork for member’s services.</p> <p>In the observed program meeting, recent or scheduled contact with natural supports were reported for 54% of members with identified natural supports. The team documents natural support contacts in the member health record and within individual member calendars.</p> <p>Of the four members interviewed, two reported having recent contact between the team and their natural supports. One member reported almost daily contact between the team and their natural support.</p> <p>Per the provided member calendars, 36% of natural supports were contacted and averaged about five contacts a month. Of the ten randomly selected records, 60% had documented natural support contacts by ACT staff resulting in an average of three contacts per month.</p>	
S7	Individualized Co-Occurring	1 – 5	At the time of the review, there were 57 members (58%) with identified co-occurring	<ul style="list-style-type: none"> <li>Continue efforts to provide an average of 24 minutes, or more, per week of</li> </ul>

	Disorders Treatment	4	<p>disorders. Staff reported that approximately 80% of members with co-occurring disorders engaged in individualized substance use treatment in the past month, typically receiving four 20 to 30 minute sessions a month. Sessions primarily occur within the community and telemedicine, as needed, for members that are justice involved (incarcerated).</p> <p>Member calendars for the past month identified 48 members with co-occurring disorders engaged in individual substance use treatment resulting in an average of 12 minutes per week per member with co-occurring disorders.</p> <p>Reviewers were provided with the curricula utilized to guide substance use treatment which included <i>Co-Occurring Disorders: Integrated Assessment and Treatment of Substance Use and Mental Disorders</i> (Atkins, n.d.).</p> <p>Of the five member records with identified co-occurring disorders, one record had evidence of individual substance use treatment. In this record, the member had three individual substance use treatment appointments that averaged 54 minutes per session.</p>	structured individualized substance use treatment services for all members with co-occurring disorders.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 3	The Co-Occurring Disorders Specialists each facilitate a weekly co-occurring disorders treatment group, resulting in two groups per week held at the clinic. Staff reported that members at any stage of change can attend either group and utilize harm reduction and stagewise approaches to engage members in different stages within the group. Staff reported	<ul style="list-style-type: none"> <li>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.</li> </ul>

			<p>that 14 members with co-occurring disorders attended a co-occurring group in the past month.</p> <p>Per the group sign-in sheets provided for a recent month period, 15 (26%) unique members with co-occurring disorders attended at least one group.</p>	<ul style="list-style-type: none"> <li>On ACT teams, all staff participate in engaging members with co-occurring disorders diagnosis to participate in treatment groups. Ensure specialists, not only the Co-Occurring Disorders Specialists, engage members to consider group treatment.</li> </ul>
S9	Co-Occurring Disorders Model	1 – 5 4	<p>Staff reported utilizing the Integrated Dual Diagnosis Treatment model, currently known as the Integrated Treatment for Co-Occurring Disorders model, when working with members with co-occurring disorders. Staff reported utilizing a stagewise approach and tailoring interventions based on a member’s stage of change, such as utilizing motivational interviewing with members in the pre-contemplation stage and encouraging members in maintenance to share their stories of recovery with other members. All staff interviewed reported encouraging harm reduction over abstinence. Examples of harm reduction included encouraging members to use less substances, and to use substances in a safer manner such as encouraging the use of fentanyl testing kits and having opioid reversal medications on hand (e.g., naloxone). Staff encourage members to attend co-occurring disorders treatment groups but will support members that want to attend outside groups such as Alcoholics Anonymous. The team will refer members to withdrawal management facilities, and staff reported that the agency primary care provider offers medication for opioid use disorders services.</p>	<ul style="list-style-type: none"> <li>Continue to provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as <i>Integrated Treatment for Co-Occurring Disorders</i>, in the principles of a <i>stage-wise approach</i> to interventions, the EBP of <i>harm reduction</i>, and <i>motivational interviewing</i>.</li> <li>In addition to documenting clinical recommendations, ensure that treatment plans include corresponding goals that reflect each member’s individualized needs. Plans should outline specific team interventions to address substance use within the recovery framework of services provided to support members in moving toward their recovery goals.</li> <li>Lead members in substituting harm reduction language both verbally and within service plans. Encourage members to identify a reduction of use goal when a desire for abstinence is expressed.</li> </ul>

			<p>Staff reported receiving weekly all-site trainings from the clinical director that cover co-occurring disorders treatment best practices. Staff reported that the Co-Occurring Disorders Specialists have facilitated discussions and provided training to the team regarding co-occurring disorders treatment.</p> <p>Based on the 10 randomly selected member records, there were five members with identified co-occurring disorders. Of these five members, two had identified substance use disorder diagnoses, and two had substance use treatment related goals. Some treatment plans had traditional language such as “sobriety goals” and members “maintaining sobriety.”</p>	
S10	Role of Consumers on Treatment Team	1 – 5 5	<p>Staff reported at least one staff on the team that identifies as a peer and has lived or living psychiatric experience. It was reported this staff also shares their experiences and stories of recovery with the team and members. This staff has the same level of responsibilities as other staff and advocates on behalf of members.</p> <p>Three of the four members interviewed reported being aware of there being a peer on the team. One member reported valuing having a peer on the team because it gives members hope of recovery.</p>	
<b>Total Score:</b>		<b>128</b>		

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

6.	Responsibility for Hospital Discharge Planning	1 - 5	5
7.	Time-unlimited Services	1 - 5	5
	Nature of Services	Rating Range	Score
1.	Community-Based Services	1 - 5	5
2.	No Drop-out Policy	1 - 5	5
3.	Assertive Engagement Mechanisms	1 - 5	5
4.	Intensity of Service	1 - 5	4
5.	Frequency of Contact	1 - 5	4
6.	Work with Support System	1 - 5	5
7.	Individualized Co-Occurring Disorders Treatment	1 - 5	4
8.	Co-occurring Disorders Treatment Groups	1 - 5	3
9.	Co-occurring Disorders Model	1 - 5	4
10.	Role of Consumers on Treatment Team	1 - 5	5
<b>Total Score</b>		<b>4.57</b>	
<b>Highest Possible Score</b>		<b>5</b>	