ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: John Hogeboom, Chief Executive Officer
Lauren Chadwick, Director of Seriously Mentally Ill Services
Stacey Ellis, F/ACT Seriously Mentally Ill Administrator

From: Kristy Crawford, MA, MBA
Kerry Bastian, Registered Nurse
AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with 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 Evidence-Based Practice (EBP).

Method

On January 21 – 23, 2025, Fidelity Reviewers completed a review of the Community Bridges, Incorporated (CBI), Forensic Assertive Community Treatment (FACT) One team. This review is intended to provide specific feedback in the development of your agency's ACT services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

CBI operates multiple locations across Arizona, offering services such as supportive housing, crisis stabilization, ACT, and in the Central Region of Arizona, the organization manages three ACT teams and two FACT teams. The individuals served through the agency are referred to as *clients* and *members* but for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

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

During the fidelity review, reviewers participated in the following activities:

- Remote observation of an ACT team program meeting on January 22, 2025.
- Individual videoconference interview with the Clinical Coordinator.

- Individual videoconference interviews with two Co-Occurring Disorders Specialists, the Employment Specialist, the ACT Specialist, and the Peer Support Specialist, for the team.
- Individual phone interviews with two members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, Agency SMI Administrator, and representatives from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system. The sample included members from the following health plans: contractor with a Regional Behavioral Health Agreement, and Other (Medicare, private, other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; member calendars; copies of cover pages of substance use disorder treatment materials utilized; co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and 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. It is a scale that assesses 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 & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Program Size – The team is adequately staffed with ten staff, capable of providing necessary staffing diversity, to 78 members, with an 8:1 ratio.
- Responsibility for Crisis Services - The ACT team provides 24/7 crisis support to members by phone and in the community after business hours and weekends. There are staff scheduled to work on weekends for additional member support.
- Intake Rate and Time Unlimited - The team maintains a steady admission rate which allows staff and members the necessary time and space to support varying levels of onboarding needs for new admissions. In the past year, two members graduated with significant improvement, and 1-3 more are expected to step down within the next year.
- Assertive Engagement – Staff utilize assertive outreach including phone calls, home visits, and checking in with natural supports. When members are closed, they are able to return anytime.

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

- Practicing ACT Leader – Clinical Coordinator should increase in-person services to provide at least 50% direct care by delegating administrative tasks.

- Continuity Of Staffing – The team experienced a high rate of turnover of staff (83%). Optimally, turnover should be no greater than 20% over a two-year period. Recruit and retain experienced staff while providing training and guidance for specialty roles. Promoting a shared caseload fosters collaboration and unity in delivering member services.
- Frequency of Contact – The team averages 2 in-person contacts per week, increase support for members that receive a lower intensity and frequency of service. ACT teams provide members with an average of four (4) or more in-person contacts weekly.
- Work with Natural Support System – The records reviewed indicated contact with two natural supports. The program meeting observed mentioned 14 natural supports but lacked further discussion of recent interaction. Enhance engagement with natural supports by providing skills and support, with or without the member present. Ensure consistent documentation of all contacts and offer training on strategies to help members build and utilize their support networks.
- Co-Occurring Disorders Groups – The team has limited involvement by members in co-occurring disorders group treatment. Increase the engagement and participation of members in substance use treatment services. The entire ACT team is responsible for engaging members in substance use treatment services. Ensure all ACT staff, not just Co-Occurring Disorder Specialists engage members in treatment groups. Provide training on effective engagement strategies to support participation.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The FACT team supports 78 members with ten full-time equivalent direct service staff, excluding the psychiatric prescriber and program administrator. The team maintains an appropriate member-to-staff ratio of approximately 8:1. Staff on the team include a Clinical Coordinator, two Registered Nurses, two Co-Occurring Disorder Specialists, Employment Specialist, Independent Living Specialist, Peer Support Specialist, ACT Specialist, and a Housing Specialist.	
H2	Team Approach	1 – 5 3	Staff reported the use of a weekly rotating zone system so members can engage with a diversity of staff in the community. Each member of staff is assigned a caseload of ten members, managing administrative tasks and serving as the primary point of contact for system partners. Staff reported meeting with at least ten members per week. Most team members work four ten-hour days each week, including coverage on weekends. Nurses operate within their own zone rotations, tailored to address the specific needs of the members. Members interviewed reported not having in-person contact with anyone on the team but having phone contact with at least one staff in a recent two-week period. Of ten randomly selected member records reviewed, for a month period, a median of 60% received in-person contact from more than one	• Ideally, 90% of ACT members have in-person contact with more than one member of staff in a two-week period. • To enhance service delivery and support recovery from mental illness, increase in-person contact with members so that 90% of members interact with more than one staff member every two weeks. This approach ensures members benefit from the diverse perspectives and expertise of the team while also reducing the burden of responsibility on individual staff members. Support staff in moving away from functioning solely as case managers and instead operate within their areas of specialization, focusing their in-person contacts on addressing the goals and objectives outlined in member service plans.

			member of staff from the team in a two-week period.	
H3	Program Meeting	1 – 5 5	The team meets in person five days a week. All staff, including the psychiatric prescriber are expected to attend on their scheduled workdays. During meetings, the team reviews all members on the roster, discussing key areas such as current stage of change, housing needs, employment, inpatient or residential treatment updates, jail visits, outreach attempts, natural support, and planned future engagement. The meeting observed was facilitated by the Co-Occurring Disorders Specialist, who announced member names from the roster, identified the zone and confirmed upcoming contact and appointments. The team collaboratively reviewed and planned for engagement based on member needs. Limited clinical direction or guidance was provided during the meeting.	
H4	Practicing ACT Leader	1 – 5 2	The Clinical Coordinator re-joined the team in November of 2024, and has over a year of combined experience in the role. The Clinical Coordinator estimates providing 10-14 hours of direct in-person services weekly, including skills groups, informal therapeutic support, and home visits. A recent productivity report showed the Clinical Coordinator delivered direct services to members 6% of the time expected of other ACT specialists, whose standard in-person service expectation is 28 hours per week. Among the 10 records reviewed, there were two instances of the Clinical Coordinator coordinating with the prescriber for medication	• Optimally, the ACT Clinical Coordinator delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff. Increase in-person member contact. Practicing ACT leaders can engage in a range of member care needs including providing counseling/psychotherapy, facilitating or co-facilitating co-occurring disorders treatment groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffing's, shadowing and mentoring specialists delivering community-based

			refills, engaging with an inpatient team, and facilitating a group. *The fidelity tool does not accommodate delivery of telehealth services.* *This item is dependent on the Provider productivity expectation.*	services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery. • 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. Transfer responsibilities not necessary to be conducted by the ACT leader to administrative or other ACT staff.
H5	Continuity of Staffing	1 – 5 1	Based on information provided, and reviewed with staff, the team has experienced a turnover of 83% during the past two years. Twenty staff left the team. Positions that experienced high turnover include four Clinical Coordinators, three Registered Nurses, and three ACT Specialists.	• Strive for a less than 20% turnover rate. • If it has not been 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 their supports, as well as reducing the potential burden on staff. • Support specialty staff to work in their area of interest and expertise with members. Research shows staff remain in positions longer when supported in their roles by being provided with supervision and training in their specialty practice.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the team operated at approximately 80% of full staffing capacity. The team had 29 months of vacancies. Positions with the highest vacancies included the Clinical Coordinator, Registered Nurses and ACT Specialist.	• Continue efforts to retain qualified staff with the goal of operating at 95%, or more, of full staffing annually.

H7	Psychiatrist on Team	1 – 5 5	The team has a full-time Doctor of Nursing Practice and Dual-Certified Psychiatric-Mental Health and Family Nurse Practitioner (DNP, PMHNP-BC, FNP-C) serving as the prescriber for 78 members. They work four days per week with the team and provide temporary coverage for another agency team one day per week. Responsibilities include evaluations, diagnoses, medication management, refills, consultations with inpatient teams, and coordination with behavioral health residential facilities. Members are seen at least once every 28 days or as needed. On Fridays, the prescriber conducts community visits, including in members' homes, inpatient treatment facilities, and jails. They are accessible via email, messaging, phone, or in-person at the clinic. Additionally, they participate in the on-call rotation for after-hours coverage for the agency.	• Should the member census increase past 80, increase the Prescriber's time assigned to the team. ACT teams with a 100-member roster have one full-time psychiatric prescriber assigned to the team.
H8	Nurse on Team	1 – 5 5	The team has two Registered Nurses working four ten-hour days, providing services both in the office and in the community. Nurse responsibilities include coordinating care with inpatient facilities, primary and specialty providers, conducting nursing assessments, health risk evaluations, and administering injections. The Nurses primarily operate in the community, aiming for one office day to coordinate with Primary Care Physicians and to provide in-office injections. While not assigned fixed zones, Nurses create their own daily zones to meet members based on medical concerns and frequency needed. The nurses are readily available on scheduled workdays and participate	

			in the agency's on-call rotation for after-hours coverage.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 4	The team has two Co-Occurring Disorders Specialists, each with over one year of experience in providing substance use treatment services to members. Resumes provided show both specialists hold a Master's degree in Addiction Counseling. Both receive at least one monthly clinical supervision from a qualified licensed professional for substance use services. Training records show one specialist completed over 15 hours of substance use treatment training. The other specialist had one substance use treatment-related training in the past two years.	• Provide eight hours of annual training for substance use treatment providers on co-occurring disorders best practices, including the stage-wise approach, harm reduction, and motivational interviewing. These specialists can then cross-train staff, guiding interventions based on members' treatment stage.
H10	Vocational Specialist on Team	1 – 5 2	The team has one Employment Specialist with one year of experience. Training records provided lacked evidence of vocational training. The Rehabilitation Specialist position remains vacant.	• ACT teams maintain two full-time Vocational Specialist staff with at least one year's experience providing employment support. • Provide ongoing training, guidance, and supervision to Vocational Specialist staff related to support and best practices that aid members to obtain competitive positions in integrated work settings. Consider focusing training on techniques to engage members to consider employment and job development strategies, the importance of supporting in-person employer contact soon after members express an employment goal, and the provision of follow-along supports to employed members.

				• When the team is in a better staffing position, if not done so already, support Vocational Specialists to attend regional training and support meetings provided by the local mental health authority.
H11	Program Size	1 – 5 5	At the time of the review, the team was comprised of eleven staff, including the psychiatric prescriber. The team is of sufficient size to adequately provide services to members. Currently, the Rehabilitation Specialist is vacant.	
O1	Explicit Admission Criteria	1 – 5 5	The team follows *Mercy Care FACT Admission Criteria* to screen new referrals, primarily received from a Regional Behavioral Health Agreement contractor, outpatient clinics, and probation or parole officers. Screening can be conducted by any specialist, mainly the Clinical Coordinator, one Co-Occurring Disorders Specialist, and two agency Clinical Directors as additional support if needed. The team denies any pressure from administration to admit members. Eligibility is based on a qualifying diagnosis with a criminal history or legal involvement. Service intensity and engagement expectations are explained, and participation is voluntary. Approved referrals are reviewed by the team, including the prescriber, before final acceptance, with members having the ultimate decision to join the team. The team currently has no formal recruitment mechanisms but has recently seen an increase in referrals.	

O2	Intake Rate	1 – 5 5	The team maintains an appropriate admission rate, with January having the highest intake in the past six months, adding three new members to the roster.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team provides psychiatric services and medication management, substance use treatment, and employment/rehabilitative services. The team is not credited for the following service: Housing Support- At the time of review between 18-26 members resided in settings where ACT services are duplicated. Counseling/Psychotherapy - The team does not include a licensed professional to provide counseling/psychotherapy. At the time of the review, no members were receiving formal individual counseling from the team. One member receives individual counseling off-team.	In the EBP of ACT, it is expected that all behavioral health services be 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 where all housing support and case management responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all services and support from the team. • Counseling/psychotherapy is available to members on ACT teams and provided by ACT staff. This staff will also act as a generalist within the team.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24/7 crisis response, with on-call phone coverage rotating weekly among the FACT team specialists and the Clinical Coordinator as backup support. Staff respond to	

			crisis calls anytime, offering phone support, community response, risk assessments, safety plan updates, and hospitalization coordination when necessary. For additional guidance, specialists consult with an on-call Clinical Coordinator, however, the on-call may not be assigned to the team. Members interviewed were knowledgeable of the 24/7 support. One member reported using a neighbor for support after hours. A second member reported a negative experience of being hung up on when calling the on-call line for support.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported the team is actively involved in all psychiatric hospital admissions, unless a hospitalization occurs without their notification. When a member is in a crisis, staff assess willingness for voluntary admission and facilitate transport to stabilization units in the community or CBI facilities. After business hours, the on-call Clinical Coordinator provides directions, and staff stay with the member until admission, advocating on their behalf. For involuntary admissions, staff consult with the team psychiatric prescriber or the Clinical Coordinator, complete a risk assessment, and file a petition if necessary. Within 24 hours of admission, the team establishes hospital contact, with the nurse conducting nurse-to-nurse communication and the prescriber coordinating with hospital providers.	• ACT teams, performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admission. Evaluate what contributed to members not seeking team support prior to self-admission. • Maintain regular contact with members and their support networks, both natural and formal. This may result in earlier identification of issues or concerns relating to members, allowing the team to offer additional support, which may reduce the need for hospitalization.

			Per review of data with staff relating to the ten most recent psychiatric hospital admissions, which occurred over a two-month time frame, the team was directly involved in 40%. For those admissions the team was not involved members self-admitted without seeking team support.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that the team strives to be involved in all psychiatric hospital discharges, though some hospitals and crisis centers discharge members without contact with the FACT team. Discharge planning begins upon notification of hospitalization, involving coordination with case managers, nurses, and social workers to arrange housing, treatment, and referrals. The team maintains ongoing communication with the hospital via email and staffing discussions. If a member is discharged unexpectedly, staff will begin immediate outreach and ensure follow-up care. A five-day face to face follow-up is conducted to monitor medication adherence, schedule necessary PCP appointments, and assess stability. Members are scheduled to see the team psychiatric prescriber within 72 hours, and medication sheets are updated accordingly. The team also notifies guardians, probation officers, and other necessary supports to facilitate a smooth transition. Per the review of data with staff relating to the last eight psychiatric hospital discharges, the team was directly involved in 100%. These admissions occurred over a two-month period.	

O7	Time-unlimited Services	1 – 5 5	In the past year, two members graduated from the team with significant improvement. The team anticipates 1-3 members will be ready to step down to a supportive team within the next year.	
S1	Community-based Services	1 – 5 4	Staff reported 60 - 80% of in-person contacts with members occur in the community. Results of ten randomly selected client records reviewed show staff provided services a median of 65% of the time in the community. Documented services include home visits, independent living skills training, and medication management and delivery.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities, where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1 – 5 4	According to data provided and reviewed with staff, the team had ten clients that dropped out of the program in the past year. The team retained 89% of the total number of clients served in the past 12 months. Two members could not be located, two declined services, and four members transferred to the Department of Corrections.	• ACT teams ideally retain 95% of the entire caseload yearly. Work to retain membership in ACT. Several factors can impact this number positively including a clear admission policy, consistency in staffing, natural support involvement, assertive engagement practices, and taking a recovery perspective and client-centered approach to member care.
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff rotate engagement efforts to build rapport with members, and while members can decline services, or decline to engage, outreach continues for several weeks before closure, with the option to return anytime. Staff can use Natural Supports to help locate members or receive updates on their status. Additionally, staff can contact Release of Information contacts and review the Health Information Exchange reports. Outreach efforts include electronic methods such as making phone calls and checking jails or morgues, as well as physical outreach like visiting locations the member is	

			known to frequent, contacting guardians, probation and parole officers, or payees. Outreach follows a structured protocol of two electronic and two physical attempts weekly, tracked via an outreach calendar. The team closes cases after eight weeks unless the member is under Court-Ordered Treatment.	
S4	Intensity of Services	1 – 5 3	Per review of ten randomly selected client records, during a month before the fidelity review, the median amount of time the team spends in person with members per week is approximately 65 minutes. The record with the highest weekly average being 191 minutes of service. One member record had zero contact documented for the month period. Seven out of ten records included phone and videoconference contact with members. *The fidelity tool does not accommodate delivery of telehealth services.*	• Continue efforts to provide intensive services to members. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. Ensure services are accurately documented.
S5	Frequency of Contact	1 – 5 3	Of the ten records randomly sampled, staff provided a median frequency of 2.25-person contacts to members per week. The record with the highest frequency was 10.75. One record had zero in-person contact documented.	• Improved outcomes are associated with frequent contact. Members of ACT teams find limited success with traditional office-based treatment and often require more frequent community contact to be assessed for current needs and to receive ongoing support. On ACT teams, all staff are invested in delivering a high frequency of contacts with members, and contacts are individualized, aligning with members' recovery goals. • Increase the frequency of contact with members, ideally averaging four (4) or

				more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact.
S6	Work with Support System	1 – 5 1	The data provided reviewers identified 54 members with natural supports (non-paid supports). Staff reported that this number includes both actively engaged and inactive natural support, but the team does not consistently engage all of them. The team documents contact within the member records via contact notes. Staff reported contact happens at least once weekly, either by phone or during home visits. During the observed program meeting, few contacts were identified and discussed. Records indicate an average of 0.20 contacts per member's natural support within 30 days, highlighting minimal engagement.	• Increase contacts with natural supports to an average of four (4) per month for each member with a support system. As much as possible, contact natural supports during the natural course of delivery of services provided to members. • Assist members in developing a natural, community-based support system. Active participation with peer-run programs is a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact. • Evaluate methods of tracking or monitoring staff documentation of contacts with Natural Supports.
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	Based on the data provided and discussed with staff, there are 63 members on the roster with co-occurring disorders. Currently, 30 (48%) are receiving formal structured individual substance use treatment services. Staff report sessions range from 30-45 minutes weekly, and at a minimum members will have one session per month. Among the records reviewed, nine members had co-occurring diagnoses. Of those records five members received at least one individual counseling session. The average length of an	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders. • Monitor member engagement and participation in individual substance use treatment service delivery by the ACT team.

			individual session was approximately eight minutes.	
S8	Co-Occurring Disorders Treatment Groups	1 – 5 2	The FACT team provides three substance use treatment groups, tailored to members' stages of change— pre-contemplative, contemplative and another for action/maintenance stages. Groups are held in-person at the clinic, with up to 11 members attending monthly. A review of sign-in sheets shows 11 (17%) unique members attended one group in a month period. The curriculum includes psychoeducation, interactive activities, and games to keep members engaged.	• 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 group monthly. • On ACT teams, all staff participate in engaging members with co-occurring disorders diagnosis to participate in treatment groups. Ensure specialists, not only the CODS, engage members to consider group treatment. • Staff may benefit from training in strategies to engage members in group substance use treatment.
S9	Co-Occurring Disorders Model	1 – 5 4	The FACT team follows the Trans-Theoretical Model of Change, "Integrated Dual Disorder Treatment", and a stage-wise approach to substance use treatment, meeting members where they are in their recovery journey. Engagement in the precontemplation stage focuses on building relationships, while discussions evolve from exploring behavior change to relapse prevention. The team does not use confrontation and prioritizes harm reduction over strict abstinence, recognizing relapse as part of recovery and encouraging safer use rather than abrupt quitting. While Alcoholics Anonymous is not a required referral, it is offered as an option, and detoxification referrals are only made when medically necessary for substances like fentanyl, heroin,	• 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.*

			and cocaine. Harm reduction includes risk education, Narcan availability, and on-call crisis support. Staff receive training through *Relias*, clinical oversight, and monthly FACT/ACT meetings covering psychosocial education and medication, with CODS available for additional guidance. Of the nine records that identified members as having co-occurring disorders, seven had treatment plans that identified substance use (treatment) goals. The language used in the records identified the team being supportive of member needs and reduction of use. Staff interviewed and observed in the program meeting used language congruent with stage wise approach.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The FACT team includes at least two staff with lived psychiatric experience, with one openly sharing their recovery journey to support members. Peers provide flexible, zone-based support, fostering trust through shared experiences. While they advocate for members by relaying challenges to the team, staff were unclear on how this is communicated, and members were unaware of peers on the team. Peers share the same responsibilities as other ACT staff, contributing fully to member care.	
Total Score:		**107**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	1
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Co-Occurring Disorders Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	2
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
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 (1-5)
1. Community-Based Services	1-5	4
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	3
6. Work with Support System	1-5	1
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	**3.82**	
Highest Possible Score	**5**	