ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: August 7, 2014

To: Jennifer Starks

From: Georgia Harris
T.J. Eggsware
Karen Voyer-Caravona
Jeni Serrano
ADHS Fidelity Reviewers

Method

On August 4, 2014 and August 5, 2014, Georgia Harris, T.J. Eggsware, Karen Voyer-Caravona and Jeni Serrano completed a fidelity review of the Southwest Network-Osborn Adult Clinic, Assertive Community Treatment (ACT) 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 Maricopa County.

The *Southwest Network* Provider Network Organization (PNO) serves over 7,600 adults who are identified as having a Serious Mental Illness (SMI) in Maricopa County, Arizona. Located in the metropolitan Phoenix area, the Osborn Adult Clinic is easily accessible to its members by public transportation. Using various classroom and office spaces, the Osborn Adult Clinic offers an array of clinical services and other activities to its members via the clinical/professional staff and auxiliary co-located service providers (e.g. Terros). At the time of this review, the Osborn ACT team was comprised of eleven staff members who served a caseload of 98 individuals. The tenure of the ACT team staff ranged from five years to one day.

During the site visit, reviewers participated in the following activities:

- Interview with the ACT team leader.
- Observation of a daily ACT team meeting.
- Interviews with nine members served by the ACT team.
- Interviews with one identified Substance Abuse Specialist and two other ACT Team staff -- Independent Living Skills Specialist and Housing Specialist.
- Charts were reviewed for ten members being served by the ACT team.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model, using specific observational criteria. It is a 28-item 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*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The Osborn Adult Clinic ACT Team works diligently to provide timely services to its assigned members. Members are carefully screened for eligibility, which allows the program to maintain an appropriate size. The team benefits from having a lead psychiatrist, an engaged nurse, a number of tenured staff, as well as an integrated peer support specialist. Through much staff turnover, the team has remained consistent with managing on-call crisis situations, and the team is successful in their coordination of hospital intake and discharge planning for their members. The agency also demonstrated strengths in the following program areas:

- The member to staff ratio was below 10:1.
- Staff regularly attends the daily team meeting to provide status updates and investigate solutions to member difficulties.
- The program intakes members at a low rate, with six or less intakes per month.
- The team retained 95% or more of their caseload over the past 12 months.
- The team uses a structured, detailed and assertive eight week contact strategy for member engagement and retention.

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

Team Services and Contacts

- Each staff member has a dedicated caseload, which is limiting the ability of team specialists to function in their area of expertise. To improve continuity of care, it is recommended that the team review fidelity item H2 *Team Approach* for the benefits of offering a shared caseload. More information can be found in the SAMHSA Evidence-Based Practices Kit for ACT under *Building Your Program.*
- The team appears to rely on external and co-located services (i.e. brokered services), referring members to other agencies for the majority of ACT services (e.g. individualized counseling, substance abuse treatment, supported employment). Review referrals to determine if other providers may be involved in activities that should fall under ACT services in the community.
- While the agency documentation reflected a high number of member contacts with multiple ACT team staff, these contacts were often based on medication observations or very brief encounters in the clinic, which diminishes the intensity and

inherent value of the services actually provided. Review the type of contacts that are provided, for quality and purpose, in addition to frequency.

Practicing ACT Team Leader

- While the ACT Team Leader is committed to supporting the staff and providing members with a choice in treatment, the majority of the leader's responsibilities appear to be administrative. It is recommended that the ACT Team Leader spend at least 50% of the time providing direct services.
- If all identified administrative functions are required of the Team Leader, consider looking for other agency supports that could assist with some of these. Otherwise, this role and relative responsibilities may be an area of further review at the system level.
- To ensure that the time and services provided directly by supervisors is accurately reported, review agency and network and options for better reporting methods.

Substance Abuse Treatment

- Nearly 65% of members were identified with having a co-occurring disorder, reinforcing the vital need for an evidence-based, stage-wise approach to substance abuse treatment. All staff members would benefit from implementing a structured treatment approach that includes stages, interventions, and activities for intervening staff (such as IDDT). The team should also incorporate individualized substance abuse treatment for members, as well as treatment groups based on a proven and structured model.
- At the system, network and clinic level, review training and supervision options to ensure staff designated with a substance abuse specialty receive monitoring, support and education in their role and proven treatment models.

Vocational Specialist on Staff

- The team has been without two full-time vocational specialists for more than a year; in the most recent three months, there were zero FTEs in this position. It is recommended that the Team Leader focus on exploring clinic and network options for obtaining staff with employment or vocational background.
- At the network and ACT team level, review training and supervision options to ensure staff designated with a vocational specialty receive monitoring, support and education in their role.
- It was not clear if the ACT team emphasized skill development and support regarding vocational services that enable members to find and keep jobs. Ensure vocational supports on the ACT team assist members with rapid access to employment rather than relying on referrals to outside providers.

Agency Documentation:

- Reviewers found a lack of agency documentation to support how services are provided in several areas. Agency leadership might want to review overall team requirements for documentation, specifically:
    - There was limited information to verify actual face-to-face productivity of the team leader. More precise reporting methods will expand the leader's capacity to gauge team and individual involvement in the essential ACT activity of providing interventions in-vivo.
    - Location of service was not clearly documented in the member records. In order for the scope and effectiveness of services to be accurately determined, staff should clearly state the *location of service* in the body of the progress note.

Work with Informal Supports:

- As a component of service provision, review with the member their support system. If a member has an identified support system, efforts should be made to involve that system. If a person has other supports involved, but the person declines to allow the team to engage those supports, this should be documented along with follow up conversations revisiting this decision with pros and cons at a later date. If a support contacts the team, it would generally be appropriate for the ACT team to receive information from the support.
- At the clinic and network level, consider options for tracking team contacts with member support system(s) to ensure this measure is being accurately captured.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	(1 – 5) 5	The team currently has 10 staff line positions filled. Staffing included (1) Housing Specialist, (1) Independent Living Skills Specialist, (1) Transportation Specialist, (2) Substance Abuse Specialists, (1) ACT Specialist, (1) Peer Support Specialist, (1) Employment Specialist (1) Nurse and (1) ACT Team Leader. This count excludes the Psychiatrist and the administrative support staff. The member to staff ratio for this team was below 10:1.	• The agency and the ACT Team Leader should continue to monitor and manage the team's caseload ratio below 10:1.
H2	Team Approach	(1 – 5) 5	ACT members are being served by multiple staff members, in-person, more than 90% of the time. Each staff member assumes primary responsibility for an assigned caseload, rather than team ownership of caseload responsibility. Medication observations are assigned as a duty for each staff member in a rotation. Members were being seen by multiple staff for medication observation and other activities. Staff members enjoy working in their areas of specialization, however, assigned caseloads are impacting the team's ability to cross-specialize and therefore, provide more robust treatment.	• Review *Team approach*, which is fully-realized when the entire team shares responsibility for each member. This will allow each staff member to contribute based on their area of expertise, as appropriate. • If primary caseloads are assigned for specific paperwork-related tasks, ensure the specialty role of specialty staff is their primary function on the team. This will foster the cross-specialization of staff members needed for improved continuity of care.
H3	Program Meeting	(1 – 5) 5	This ACT team held the expectation that all team members are to attend the daily *Morning Meeting*. This meeting is scheduled for 10:30am, four days a week: Monday, Tuesday, Thursday and Friday. Wednesdays are reserved as *field days*- set apart to allow team members time for supervision, as well as the opportunity to perform daily duties without interruption. The morning meeting log that was distributed amongst team members documented the status of each	

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			member, as well as provided direction to related discussions. In many instances, team members made efforts to collaborate on the sharing of home visit and medication observation responsibilities. However, many team members opted to assume primary responsibility for the members that were a part of their assigned caseload.	
H4	Practicing ACT Leader	(1 – 5) 1	The ACT Team Leader conducts occasional hospital visits and face-to-face contacts as needed. The primary functions of the team leader Are coordination and supervision of the staff and their activities with the members. The team leader desires to "be in the field more", however, the majority of work hours are spent "being the problem solver" for the team. The estimated amount of contact for the ACT Team Leader was between 5-10% (five members a day). A productivity report was provided for the ACT Team Leader. The total number of billable units for the month was calculated as 15 hours; None of the 10 records reviewed indicated the ACT Team Leader had face-to-face contact with them during the selected period. In this case, weight was given to the agency documentation and the record review.	• Review team leader administrative activities to determine if all are essential and required through the involved stakeholders or other oversight entities. • If all leader administrative activities are deemed essential, consider if there are other supports at the clinic that could assist in completing some or all of those tasks which may allow the team leader to provide increased direct service to members. • If all identified administrative functions are required, team leader responsibilities may be an area of further review to determine if action should occur at a system level. The need for this level of intervention cannot be fully confirmed at this time. • Ensure all Team Leader service activities are documented in the clinical records for the members served.
H5	Continuity of Staffing	(1 – 5) 3	The team had 12 staff members leave in the past 24 months. The team operated with a 40-59% turnover rate in the past 2 years.	• Consider exploring the reasons employees cite for making a change in position that leads to staff turnover. This may be an area of

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				further ongoing network, clinic and system review. • Consider the use of employee satisfaction surveys to gather and gauge employee feedback. Preferably, the process would seek to identify employee satisfaction levels related to the team, clinic and system
H6	Staff Capacity	(1 – 5) 3	The team had five staff position vacancies over the past 12 months, with a peak vacancy of 2 staff in January, 2014. This team's operation at full staff capacity was between 65-79% over the past 12 months.	• Consider exploring the reasons employees cite for making a change in position that leads to staff turnover. This may be an area of further ongoing network, clinic and system review.
H7	Psychiatrist on Team	(1 – 5) 4	One full-time psychiatrist is assigned to the team. The psychiatrist is the Lead doctor for both the Southwest Network - Hampton and Osborn clinics. The Psychiatrist provides monthly supervision to the doctors at both clinics. A portion of the Psychiatrist's time is spent meeting with members from other teams. The psychiatrist works four, ten-hour days, and has walk-in hours for all clinic clients on Fridays. It was reported the psychiatrist makes the ACT clients the priority; home and hospital visits are conducted as the team deems necessary. Staff and members both confirmed in interviews that the doctor is accessible and helpful. The psychiatrist is involved in the education, coordination and planning of treatment/intervention for the members.	• Ensure that at least one full-time psychiatrist is assigned directly to a 100-member program. • Establish ongoing clinic monitoring of psychiatrist coverage to minimize the additional responsibilities and the number of non-ACT members that are served by the ACT psychiatrist.
H8	Nurse on Team	(1 – 5) 3	The team currently has one full-time nurse. The nurse is well-liked by the members and assists	• Review clinic nursing coverage options to allow the ACT team nurse additional

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			them with their needs (e.g. Medi-sets, Injections, etc.). The ACT Leader indicated an additional nurse would further improve the members' access to the medical and educational services the nurse provides. Currently, the nurse's schedule is very compact and leaves little room for her to meet members in the community, outside of emergency services.	flexibility to engage individuals. • At the clinic or network level, review options to add an additional nurse to ensure that two full-time nurses are available for a 100-member program. This would allow the nurse additional flexibility to provide services (i.e., one nurse remaining in the clinic, and one in the field).
H9	Substance Abuse Specialist on Team	(1 – 5) 5	There are two staff members with the designation of Substance Abuse Specialist on the team. It was reported that both substance abuse specialists have received at least one year of training, or clinical experience in substance abuse treatment.	• Review training and supervision options to ensure staff designated with a substance abuse specialty receive monitoring, support and education in their role, for the population served. Assure that the designated Substance Abuse Specialists are providing co-occurring disorders specific individual and group counseling sessions (See items S7 & S8)
H10	Vocational Specialist on Team	(1 – 5) 1	The team employed one new FTE –Employment Specialist on 8/4/2014. This same Employment Specialist has worked on this ACT team as a Rehabilitation Specialist from 7/7/2014 to 8/4/2014, as a 20% employee. Based on the agency documentation provided, the Employment Specialist had 28 days of verified experience. Though the new vocational specialist filled one of the two allotted positions, sufficient evidence was not provided to validate that the training and experience level of the Employment Specialist included at least one year of training or experience in vocational rehabilitation and support. Due to the newness of the Employment Specialist to this role, minimal information was provided on their function, relationship and	• Ensure vocational supports on the ACT team assist members with rapid access to employment rather than relying on referrals to outside providers. • The team does not have 2 full-time vocational specialists on the team: o At the network and ACT team level, review training and supervision options to ensure staff designated with a vocational specialty receive monitoring, support and education in their role.

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			outcomes as they relate to the ACT team. Through the use of member interviews and the member chart review, it was noted some members attended work-adjustment programs at VALLEYLIFE, and were in contact with a vocational specialist from another team. Staff interviews indicated all employment services were referred-out to Supported Employment agencies outside of the ACT team. It was not clear if the ACT team emphasized skill development and support regarding vocational services that enable members to find and keep jobs in competitive employment positions.	
H11	Program Size	(1 – 5) 5	The team consists of more than 10 full-time equivalent staff.	
O1	Explicit Admission Criteria	(1 – 5) 4	The ACT team screens referrals carefully, but occasionally bows to organizational pressure. Documentation was provided outlining the ACT referral and screening process. The team utilizes an *ACT Admission Screening* form provided by the Regional Behavioral Health Authority; an *Osborn ACT Team Pre-Referral Form* which further evaluates the appropriateness of the referral for this location; and an *ACT Criteria Checklist for New Referrals*. ACT Team Leader reposts that the team is "never forced" to accept any referrals. Though the process for ensuring the appropriateness of the referrals is well-defined. There have been instances when members who have not completed this process have been added to the team numbers. Staff reported that this "has only happened once, and [the member] was appropriate" for services, however, this does indicate on occasion, the team has included	• Review each ACT referral and maintain the established admissions process to ensure the appropriateness of each member for the team.

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			members that did not go through the standardized admission process due to organizational commitments.	
O2	Intake Rate	(1 – 5) 5	The program takes in members at a low rate. The highest intake month recorded was 05/14, with six intakes completed.	
O3	Full Responsibility for Treatment Services	(1 – 5) 3	In addition to case management, the team directly provides psychiatric services, housing support and rehabilitative support. Psychiatry is being provided by the team psychiatrist. The housing specialist on the team has helped members with ACT housing and applications for additional government voucher/grant programs. Members received independent living skills training in-vivo and learning skills that can be transferrable in a vocational setting. Staff reported the use of culturally-appropriate services while teaching rehabilitative skills in the community. In one example, a staff member would take the member to an ethnic grocery store to interact with others from her culture, while conducting a lesson on grocery shopping techniques. Despite this example, the majority of cases noted were referred to external providers for rehabilitative services. Staff and members also reported a coping-skills group (with a substance use component) is offered to the members at the clinic, every Friday. This group is dedicated to ACT members; however, it is not a substance abuse treatment specific group.	• Consider options that will broaden the scope of service in the ACT additional service areas (e.g. individualized substance abuse counseling). • Consider options that will minimize the need for the team to refer-out to agencies for services that are to be provided by the ACT team (e.g. vocational services). • At the network and clinic level, review training and supervision options to ensure staff designated with a specialty receive monitoring, support and education in their role.
O4	Responsibility for Crisis Services	(1 – 5) 5	The provision of crisis services coverage 24 hours-a-day, and 7 days a week. The ACT Team Leader reported the staff members rotate being the primary on-call staff. The backup on-call staff is always the ACT Team Leader. The members	

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			verified they have access to the on-call phone number. One member stated she regularly places a call to the on-call staff to communicate that she has taken her medications. Staff also discussed on-call services in the daily meeting on 8/4/2014.	
O5	Responsibility for Hospital Admissions	(1 – 5) 4	Of the last ten hospital admissions provided, one of them was excluded from this final calculation. The excluded admission was a member who was transferred to the team after she was admitted to the hospital. Of the nine remaining admissions, eight out of nine had ACT team involvement. One hospital admission was a self-admission by the member. The team's hospital admission involvement is 89%.	
O6	Responsibility for Hospital Discharge Planning	(1 – 5) 5	The team was involved in the hospital discharge planning of all ten of the most recent discharges. The staff is required to visit members in the hospital three times weekly. The staff members are required to contact the hospital social workers weekly and are required to be present at the hospital when a member is being discharged. During the record review, it was noted that the hospitalized members did receive face-to-face contact with the team Psychiatrist and staff. In one instance, staff was in contact with the member's family during the hospitalization period.	
O7	Time-unlimited Services	(1 – 5) 4	Four members had graduated (i.e., need for services was reduced) in the twelve-month period prior to the review. Approximately one person a year was expected to graduate. The ACT Team Leader also stated there were five graduates she was not familiar with since they preceded her tenure on this team. In the documentation provided, eight members were declared graduates, creating an 8% graduation rate.	• It is recommended that the ACT team establish a written statement of clear examples of milestones in progress that support graduation. • It is recommended that ACT team staff explicitly document in member records progress supporting graduation from ACT.

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S1	Community-based Services	(1 – 5) 3	Ten member records were reviewed to determine the ratio of services delivered in the community versus those delivered in the office. During the chart review, it was noted that the location of service was not clearly stated in the body of the note (i.e. medication observation; clinic vs. home). There was some indication that a large percentage of face-to-face contact occurred in the clinic (i.e. during visit for medication refills and groups). Of the ten member records reviewed, the percentage of community contacts ranged from 6% to 86% with a median of 50.5%.	• Location of service was not clearly stated in portions of the member records. Review team standards for documentation; documentation should clearly include location of service. • There was some indication the team relies more on external and co-located services (i.e. brokered services). Review referrals to determine if other providers may be involved in activities that should fall under ACT services.
S2	No Drop-out Policy	(1 – 5) 5	This team retained 95% or more of their case load over the most recent 12-month period. Of those members who discontinued services, only one member refused ACT team services.	
S3	Assertive Engagement Mechanisms	(1 – 5) 5	The team has a defined, eight-week engagement strategy. As a part of the eight-week strategy, staff must document the type of outreaches that were completed (e.g. attempted home visit, local jails, payee, obituaries, etc.). Staff must send out formal letters (Notice of Intent, Notice of Action) on weeks four and six of the process. If contact is made at any time during the eight-week outreach period, the process is discontinued. Examples were given of members who have been reintegrated by using this system. Legal mechanisms (e.g. Court-ordered treatment) are used whenever appropriate, especially in cases where the members were difficult to engage.	
S4	Intensity of Services	(1 – 5) 4	Ten member charts were reviewed to determine the amount of face-to-face service time spent with each member. The sum of the face-to-face service times was determined for each member.	• Consider what actions the team might take that could result in higher service intensity per member (e.g. increase in services through ACT staff, decrease in

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			From these totals, their mean values were calculated. The median value of the mean values was then determined. The median face-to-face service minutes across the ten member records fell within a range of 85-119 minutes per week. Member and staff interviews confirmed the members were being seen regularly. The members are also engaging in rehabilitative activities (e.g. house cleaning, home organization, housing applications, etc.). Staff interactions during their daily meeting displayed the team's effort to work in a cross-disciplinary manner. However, member interviews indicated a sizable portion of these visits may be brief in nature (e.g. medication observation).	brokered services though outside agencies/teams).
S5	Frequency of Contact	(1 – 5) 5	Ten member charts were reviewed to determine the amount of times per week each member is receiving contact from the ACT staff. The mean number of face-to-face contacts for each chart reviewed was used to determine the median value for this sample. The calculated team average was 4 or more contacts/week for each member. Staff and member interviews confirmed the members were being seen frequently by the ACT team staff.	
S6	Work with Support System	(1 – 5) 1	Some of the members have families that are very involved with the team. There are others, however, that do not desire to be contacted, nor do the members desire to have them contacted. "There are some we talk to once a week; there are others we talk to once a month. I can think of about four to five [families] that we are in contact with. It's not a large portion". ACT Team Leader also stated, "We try to have a lot of contact with the ones we have". One of nine interviewees confirmed that the team had contact with their family members. The other eight reported having	• As a component of regular service provision, review with the member his or her support system. If a member has an identified support system, efforts should be made to involve that system. If a person has other supports involved, but the person declines to allow the team to engage those supports, this should be documented along with follow up conversations revisiting this decision with pros and cons at a later

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			distant or estranged relationships with family members. Of the ten records reviewed, two members' families had contact with the team; one was during a hospitalization. Based on the available information, across the 98 members served on the team, it appeared the team maintained less than .5 contacts per month for each member with a support system in the community.	date. If a support contacts the team, it would generally be appropriate for the ACT team to receive information from the support. • Consider options for tracking team contacts with member support system(s) to ensure this measure is being accurately captured.
S7	Individualized Substance Abuse Treatment	(1 – 5) 1	The ACT team does not provide individualized substance abuse treatment due to the lack of licensed counselors. The Substance Abuse Specialists are "available for encouragement" to members and provide treatment groups at the clinic. Members who are in need of formal, individualized treatment are often assessed by the ACT Substance Abuse Specialists, and then referred to the co-located TERROS group or another suitable provider.	• Review team, provider, and system options related to securing or training staff to provide individual substance abuse treatment in a structured manner.
S8	Co-occurring Disorder Treatment Groups	(1 – 5) 2	The team provides an ACT-only coping skills group to members. The group is not centered solely on substance use, rather a series of coping skills to manage triggers that can lead to complications (including relapse). The group is held on Fridays and is two-hours in duration. The group curriculum is not based in a particular treatment model (i.e. stage-wise treatment); it is a collection of materials that have been selected based on member concerns and interests. The team reports that 64 of their 98 members are diagnosed with a co-occurring disorder. Approximately five members attend the group on a regular basis.	• Review the substance use treatment groups curriculum to ensure a co-occurring disorders treatment model is utilized. Several good manuals contain curriculum and strategies to engage clients in co-occurring stage-wise treatment groups. • Ensure staff designated to provide co-occurring treatment focused groups coordinate the content of the groups, track attendance at each group, and lead coordination of services related to substance use treatment on the team.
S9	Co-occurring	(1 – 5)	The team is in the early phases of embracing a	• Review options to provide training and

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	Disorders (Dual Disorders) Model	2	stage-wise approach to co-occurring disorders. All ACT staff was unfamiliar with a stage-wise approach to co-occurring disorders treatment. Multiple staff members stated the team views abstinence as the goal; however, this may not be in reach for all members. Team members were familiar with the term "harm-reduction", however, substance abuse interventions tended to be confrontational in nature. In one chart, the team Psychiatrist did identify a member in the "pre-contemplative state" and made appropriate recommendations for this individual. In the daily meeting, the team received direction from the Psychiatrist with regards to educating a member of the risks associated with substances and medications. There was also evidence of referrals to inpatient/outpatient providers for substance use treatment.	information to the ACT team to implement a stage-wise treatment approach, at the team, clinic, network and system levels. Standardizing basic tenants of the treatment may help to ensure consistent interventions across the system.
S10	Role of Consumers on Treatment Team	(1 – 5) 5	The Peer Support Specialist was identified as a full-time team member. The Peer Support Specialist is an integral part of the team and contributed information and support during the daily meeting on 08/04/2014. The Peer Support Specialist was actively involved in outreach, member contacts, and service delivery that included medication observation activities. Staff member interviews confirmed the peer support specialist is viewed as passionate and able to provide insight when dealing with challenging member circumstances. The Peer Support Specialist is given equal responsibility on the team.	
Total Score:		**3.68**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Score (1-5)
1. Small Caseload	5
2. Team Approach	5
3. Program Meeting	5
4. Practicing ACT Leader	1
5. Continuity of Staffing	3
6. Staff Capacity	3
7. Psychiatrist on Team	4
8. Nurse on Team	3
9. Substance Abuse Specialist on Team	5
10. Vocational Specialist on Team	1
11. Program Size	5
Organizational Boundaries	
1. Explicit Admission Criteria	4
2. Intake Rate	5
3. Full Responsibility for Treatment Services	3
4. Responsibility for Crisis Services	5
5. Responsibility for Hospital Admissions	4

6. Responsibility for Hospital Discharge Planning	5
7. Time-unlimited Services	4
Nature of Services	
1. Community-Based Services	3
2. No Drop-out Policy	5
3. Assertive Engagement Mechanisms	5
4. Intensity of Service	4
5. Frequency of Contact	5
6. Work with Support System	1
7. Individualized Substance Abuse Treatment	1
8. Co-occurring Disorders Treatment Groups	2
9. Co-occurring Disorders (Dual Disorders) Model	2
10. Role of Consumers on Treatment Team	5
Total Score	**3.68**