ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

Date: August 8, 2025

To: Dan Ranieri, CEO

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Introduction

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

Method

On July 14 – 16, 2025, Fidelity Specialists completed a review of the **La Frontera – Empact Tempe** 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 the central Arizona general service area.

La Frontera-EMPACT provides crisis and behavioral health services to adults, children, and families. The Tempe ACT team is a standalone ACT team, and the location exclusively serves members of the Tempe ACT team. The individuals served through the program are referred to as *clients* or *patients*, 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 July 15, 2025.
- Individual videoconference interview with the Clinical Coordinator (CC).
- Individual videoconference interviews with the Housing, Vocational, ACT, and Peer Support Specialists, as well as two Co-Occurring Disorders Specialists, one of which also serves as the Licensed Counselor for the team.

- Individual phone interviews with two (2) members participating in ACT services with the team.
- Closeout discussion with the CC, Agency ACT Manager, two agency Quality Management staff, and a representative from AHCCCS and the Health Plan.
- 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: the contractor with a Regional Behavioral Health Agreement and Other (Medicare, private, other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; 8 Week Outreach form, member calendars; copies of cover pages of substance use disorder treatment materials utilized (SAMHSA's *Integrated Treatment of Co-Occurring Disorders* toolkit, *Living in Balance Core Program (Hazelden)* and *Substance Abuse Treatment and the Stages of Change)*; co-occurring disorders treatment group sign-in sheets; resumes and training records for both the Vocational and Co-Occurring Disorders Specialist staff; ACT Team Brochure; team and group flyers; and a productivity report for the CC for a recent 30-day period.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. The scale determines the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries, and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented with little room for improvement*).

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

Summary and Key Recommendations

The agency demonstrated strengths in the following program areas:

- Program Size/Small Caseload: The team is sufficiently staffed with 11 full-time equivalent positions, offering the necessary staffing diversity to serve 98 members at a member-to-staff ratio of 9:1.
- Explicit Admission Criteria/Intake Rate: The team has a clearly defined mission to serve a target population and has maintained an appropriate intake rate, with no more than 10 admissions over the past six months.
- Responsibility for Hospital Admissions and Discharges: The team is actively involved in decisions regarding psychiatric hospitalization, including immediate assessment by the team psychiatric provider. This involvement helps maintain engagement during hospitalization and ensures coordinated care for members throughout the discharge planning process.
- No Dropout Policy: The team retained 98% of the total number of members served in the past 12 months.

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

- Community-Based Services: Consider reviewing location-of-service data to identify barriers to field-based member engagement and reinforce expectations during supervision and team meetings. Records reviewed show staff spend 54% of their time in the community. Improving documentation of community-based contacts can also ensure that service delivery aligns with team

practices and fidelity benchmarks. These efforts can help ensure members receive the full benefit of assertive, in-vivo support in their natural environments.

- Frequency of Contact: Consider reviewing contact data in team meetings to inform service delivery and the prioritization of outreach to low-contact members. Some members receive more frequent contact than others. Strengthening monitoring and clarifying expectations may help align contact frequency with ACT standards.
- Work with Informal Support System: Reinforce expectations for consistent engagement with natural supports, strengthen documentation practices, and integrate these supports into treatment planning. Regularly reviewing contact data during team meetings may help ensure natural supports are effectively leveraged to promote member recovery.
- Co-Occurring Disorders Model: The team would benefit from additional training on Integrated Treatment for Co-Occurring Disorders principles and enhanced supervisory support to ensure individual contacts with members consistently reflect stage-appropriate, best practices. Strengthening documentation of co-occurring disorders-specific interventions in both individual and group notes may reinforce alignment with the ACT model and promote continuity of care.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team currently serves 98 members and includes 11 full-time equivalent (FTE) direct service staff. This excludes the psychiatric prescriber, administrative staff, and the Primary Care Physician assigned to the team. The team has a member-to-staff ratio of 9:1. The direct service staff consists of the CC, two Registered Nurses (RN), two Co-Occurring Disorders Specialists (CODS), one Rehabilitation Specialist, one Employment Specialist, one Housing Specialist, one Independent Living Skills Specialist, one ACT Specialist, and one Peer Support Specialist.	
H2	Team Approach	1 – 5 4	Staff reported that approximately 85–90% of members interact with more than one ACT staff over a two-week period. Excluding the CC, the team follows a 4-day, 10-hour shift schedule, with three to four specialists scheduled on weekends to support member engagement and continuity of care. Caseload responsibilities are shared, with each staff overseeing approximately 10 members to manage administrative tasks such as updating service plans and assessments and securing necessary documents (e.g., state identification cards, Social Security cards). The team utilizes a regional rotation model; however, staff provided inconsistent descriptions regarding the frequency of rotation (daily or weekly) and the number of regions included.	• In the EBP of ACT, 90% of members have in-person contact with more than one staff in a two-week period.

			Members interviewed reported interacting with four to five staff each week. Of 10 randomly selected member records reviewed for a month period, 70% received in-person contact from more than one staff from the team in a two-week period.	
H3	Program Meeting	1 – 5 5	Per interviews, the team meets in person five days per week and reviews all members on the team roster at every meeting. One meeting each week is designated for staffing members with co-occurring disorders and ongoing team training. All staff attend meetings on scheduled workdays, and the Primary Care Physician participates twice weekly. During the program meeting observed, staff discussed recent engagement efforts and planned outreach activities. Topics included member engagement in treatment, stages of change and treatment, medication management updates, group participation, progress toward substance use goals, contact with natural supports, and coordination for members that are hospitalized or incarcerated. The psychiatric prescriber led the meeting, with the CC providing guidance to staff relating to the prioritization of service delivery to address member needs.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimated providing approximately 25 - 40 hours of in-person services per month. Documented examples from the records reviewed included assistance with completing a vocational profile, conducting medication observation, updating a service plan during an	• Continue efforts to provide in-person services to members 50% or more of the expected productivity of other ACT staff.

			Adult Recovery Team meeting, and completing a comprehensive assessment. The productivity expectation for in-person service delivery for team staff is 105 hours per month. A productivity report for a recent 30-day period showed the CC delivered 40.8 hours of direct service, resulting in approximately 39% of the expected productivity for ACT staff. *This item is dependent on the Provider productivity expectation.*	
H5	Continuity of Staffing	1 – 5 4	Based on the information provided and reviewed with staff, five staff left the team, resulting in a turnover rate of 21% during the past two years. The positions affected by turnover during this period were the RN and Employment Specialist roles.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports the therapeutic relationship between members and staff and promotes team cohesion.
H6	Staff Capacity	1 – 5 5	Over the past 12 months, the team has achieved approximately 97% of full staffing capacity. During this period, the RN position was vacant for four months, during which the team operated with only one nurse.	
H7	Psychiatrist on Team	1 – 5 5	The team includes one dedicated psychiatric provider, a Psychiatric Mental Health Nurse Practitioner (PMHNP), that works exclusively with members of the team. The PMHNP primarily provides services to members in person at the clinic, with home visits conducted as needed for individuals with medical or physical limitations. Staff and members reported that psychiatric appointments occur approximately every 30 days. During the observed program meeting, the PMHNP led the discussion, identified missed and upcoming appointments, and raised concerns	

			regarding members' engagement in treatment. Records reviewed showed documented PMHNP appointments for eight members; one record reflected ongoing efforts to engage a member that missed a scheduled visit.	
H8	Nurse on Team	1 – 5 5	The team is staffed with two full-time RN that support the caseload of 98 members. Responsibilities include coordinating care with the PMHNP, monitoring medications, providing medication education and training, triaging medical concerns, conducting home and hospital visits, and delivering medications to members. The RN also monitors vitals and identifies unreported health concerns for follow-up with psychiatric and medical providers, including the assigned Primary Care Physician.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 4	The team includes two Co-Occurring Disorder Specialists. One CODS is a Licensed Professional Counselor (LPC) with several years of experience in substance use treatment and recent relevant training. The second CODS has been in the role for several years. Training documents provided lacked evidence of recent training related to substance use or co-occurring disorders treatment. This staff is not receiving clinical supervision from a qualified professional specific to substance use treatment delivery.	• Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., the *stage-wise approach* and the evidence-based practice of *harm reduction*. The CODS support the team by cross-training staff and guiding interventions based on members' stage of change and the team's adopted co-occurring disorders model. • Ensure Co-Occurring Disorders Specialist staff are provided with regular supervision from a qualified professional to support delivery of individual and group substance use treatment services in an integrated treatment model approach.

H10	Vocational Specialist on Team	1 – 5 4	The team includes one Employment and one Rehabilitation Specialist. Reviewers received resumes for both specialists, which reflect relevant experience in supporting members with obtaining and maintaining employment in integrated work settings. Both specialists lacked recent vocational-related training.	• 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.
H11	Program Size	1 – 5 5	At the time of the review, the team was comprised of 12 FTE staff, including the PMHNP. The team is of sufficient size to adequately provide services to members and has no vacant positions.	
O1	Explicit Admission Criteria	1 – 5 5	Per interviews, the team follows the *Mercy Care ACT Admission Criteria* to screen potential members. Eligible individuals must have a serious mental illness (SMI) designation, demonstrate high service needs (e.g., frequent crisis service utilization or hospitalizations), and have difficulty participating in traditional outpatient case management and a willingness to participate in services. Referrals are typically submitted internally, or by external providers such as local hospitals, or the contractor with the regional behavioral health agreement (RBHA). The CC is primarily responsible for conducting screenings, typically within 72 hours of receiving the referral, often in the community. After confirming the willingness of the member to participate in services, the team PMHNP consults	

			with the referring psychiatric prescriber and makes the final admission decision. Upon approval, staff contact the member to schedule services.	
O2	Intake Rate	1 – 5 5	Based on data provided and reviewed with staff, the team has an appropriate rate of admission. The team has accepted a total of 10 new members during the past six months, with no more than three admissions monthly.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services and medication management, counseling/psychotherapy, substance use treatment, and employment/rehabilitative services. Per the information provided and reviewed with staff, approximately 29 members are receiving housing support. Of those, approximately 15 are supported by the team. Fourteen percent of housed members reside in staffed settings where service duplication occurs, including Flex Care, residential treatment, and halfway homes.	*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.* • ACT teams assist members to find housing in the least restrictive environments, which can reduce the possibility for services overlapping with other housing providers. Help members to explore low-income housing options to increase their housing choices. For members with histories that limit the availability of housing options, consider legal measures to expunge criminal records.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour crisis support to members and uses a rotating on-call schedule, with one staff member assigned daily. The licensed CODS, PMHNP, and RN are excluded from the rotation; the CC serves as the backup, offering support to staff when needed. Crisis support is provided to members via phone or in-	

			person, based on need. Staff assess for danger to self (DTS), danger to others (DTO), and other urgent concerns, first attempting de-escalation by phone before responding in the community when needed. When hospitalization is warranted, staff coordinate care, including initiating petitions to court-order treatment or providing transport when safety is not a concern. Members interviewed confirmed access to staff outside of regular business hours, including evenings and weekends. Staff contact information, including the on-call number, is provided through brochures, business cards, and other materials upon admission to the ACT team.	
O5	Responsibility for Hospital Admissions	1 – 5 5	Staff reported the team is actively involved in all psychiatric hospital admissions. During crises, staff will employ motivational interviewing techniques to assess member needs. When safe, members are transported to the clinic for immediate evaluation by the PMHNP or Nurse. When hospitalization is deemed necessary, staff first attempt to obtain the member's consent. When the member lacks insight, staff initiate the involuntary petition process. Team members remain involved throughout the admission process, providing or arranging transportation and coordinating with hospitals, informal supports, and law enforcement to facilitate a smooth transition. Records reviewed showed the team responding promptly to crises in the field, collaborating with	

			emergency contacts, and consistently following up during and after hospitalization. Per a review of data with staff relating to the 10 most recent psychiatric hospital admissions, which occurred over a three-month time frame, the team was directly involved in 100%.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that discharge planning begins at admission. The team participates in inpatient meetings 1–3 times per week, facilitates provider-to-provider communication, and collaborates with informal supports when appropriate. Discharge planning activities include assessing readiness, reviewing treatment options, ensuring medication coordination, and linking members to services such as residential treatment, substance use programs, and in-home supports. The team also provides transportation from the hospital and retrieves newly prescribed medications at discharge. Following discharge, a five-day follow-up protocol is implemented, which includes daily in-person contact with a team specialist, PMHNP follow-up within 72 hours, a primary care appointment within seven days, and a nursing visit within the same week. Hospital discharge planning was discussed during the program meeting observed. Based on a review of data with staff relating to the 10 most recent psychiatric hospital discharges, which occurred over a three-month period, staff were directly involved in 100%.	

O7	Time-unlimited Services	1 – 5 5	Data provided showed one member graduated from the team with significant improvement in the past 12 months. Staff estimated one to two members are anticipated to graduate in the next 12 months.	
S1	Community-based Services	1 – 5 3	Staff interviewed reported that 80 - 90% of in-person contacts with members occur in the community. Results of 10 randomly selected member records reviewed show staff provided services a median of 54% of the time in the community. Records indicate the PMHNP conducted at least one home visit in the last 30 days. Registered Nurses were documented providing home-based services, including medication observation, administration of injections, and health education. Additionally, records showed specialists completing home visits to engage natural supports, deliver life skills training, provide support for medical appointments, and implement co-occurring disorder interventions in the community. Members interviewed reported receiving community visits two to three times weekly.	• 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 5	According to data provided and reviewed with staff, the team had two members that left the program in the past year. For both members, staff reported that the outreach process was completed; however, the individuals could not be located. The team retained 98% of the total number of members served in the past 12 months.	

			When members no longer require the intensity of ACT services, staff meet with them to discuss reducing service frequency and intensity. Upon mutual agreement, the service plan is updated to reflect the transition. Staff reported assessing for sustained stability over a minimum of three months, including medication adherence, a stable living environment, independent appointment attendance, and the ability to arrange transportation without staff assistance.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reported using multiple assertive engagement strategies to retain and re-engage members, including street outreach, coordination with probation or parole officers, and use of court-ordered treatment mechanisms when appropriate. Outreach efforts involve visiting known locations, contacting informal supports, and initiating wellness checks when members are unresponsive to staff contact attempts. During the program meeting observed, the team discussed outreach plans for disengaged members, identifying staff responsible for follow-up, anticipated contact locations, and possible next steps. Reviewers were provided with the *Mercy Care ACT Manual* outlining assertive engagement protocols, along with an *8-Week Outreach* form**.** While the team shared documentation to support their outreach efforts, staff provided inconsistent descriptions regarding the frequency and duration of outreach activities. Despite this, staff consistently reported that most disengaged members are typically located and re-engaged in services within a few weeks.	• Increase assertive engagement efforts with members. Ideally, outreach is carried out by multiple ACT staff, drawing from motivational interviewing skills, allowing members a diverse group with whom to connect, and is then documented in member records. • Ensure staff are familiar with the outreach expectations outlined in the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual.* • Consider identifying factors that would initiate immediate member follow-up from the team (e.g., missed psychiatric/nurse appointments, missing scheduled visits with staff specialists).

			Records reviewed showed that engagement lapses from the ACT staff ranged from 7 to over 14 days, with limited documented outreach attempts.	
S4	Intensity of Services	1 – 5 3	Per a review of 10 randomly selected member records during a month period before the fidelity review, the median amount of time the team spent in person with members per week was approximately 54 minutes. The highest weekly average for in-person services was 114.75 minutes, while the lowest was 14 minutes.	• Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. • Ensure staff are trained in appropriate documentation standards so that services and service time are accurately reflected in member medical records. Some documentation in member records lacked detail regarding the encounter.
S5	Frequency of Contact	1 – 5 2	Of the 10 randomly sampled records, ACT staff provided a median frequency of 1.63 in-person contacts to members per week. The record with the highest frequency of weekly in-person contact was 6.75, while two records reflected the lowest frequency at 0.5 contacts per week. Phone contact was documented in 60% of records, with a median frequency of once per month. Two records indicated the team provided videoconference support once monthly. The median duration of all telehealth methods was 6.88 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the frequency of contact with members by ACT staff, optimally averaging four (4) or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have diverse needs/goals, and frequency of contact should be determined by those needs and immediacy. • Teams may benefit from routinely reviewing contact data, assessing barriers to in-person service delivery, and integrating discussions of contact frequency into supervision and team meetings. These efforts can help ensure that service intensity remains aligned with member needs and the expectations of the ACT model.

S6	Work with Support System	1 – 5 2	Data provided identified 42 members (43%) with natural supports. Staff reported contacting natural supports at an average frequency of once per week. These interactions are reviewed during daily program meetings, documented in member records, and tracked via a team-wide email thread. During the program meeting observed, staff reported direct contact with natural supports for approximately 15 members, most commonly by phone. One interviewed member stated that the team engages with their supports on an as-needed basis rather than routinely. Records reviewed showed an average of 0.20 contacts with natural supports over a 30-day period, with two records indicating a single instance of staff interaction with a member's natural support.	• 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. • Ensure consistent documentation of contacts with natural supports occurs, including contact by phone, email, text messages, and in person.
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	At the time of the review, 67 members were identified with co-occurring disorders. It is estimated that 60 of these members participate in weekly structured individual substance use treatment with one of the CODS staff. Specialists reported holding weekly or biweekly sessions with members primarily in person, with occasional use of office-based, telehealth, or phone sessions as needed. Of the records reviewed, 80% identified members with co-occurring disorders; all but one of these included individual co-occurring treatment sessions lasting at least 30 minutes. Sessions typically ranged from 23 to 30 minutes.	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders. • Consider monitoring member engagement and participation in individual substance use treatment. • Explore training on strategies to engage members in substance use treatment. On ACT teams, all staff engage members with co-occurring disorders to participate in treatment groups based on their stage of change, with content reflecting stage-wise treatment approaches.

				• Document the offering of services and the delivery of individual treatment to members with co-occurring disorders.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 2	The team provides three substance use treatment groups offered weekly in-person at the office that are facilitated by one of the CODS. Staff interviewed reported that 24-40 members with co-occurring disorder attend at least one group per month. Member records reviewed showed one member receiving group treatment. A review of sign-in sheets showed that eight (12%) unique members attended at least one group in a month period. Reviewers were provided with the following reference materials: *Substance Abuse Treatment and the Stages of Change*, SAMHSA's *Integrated Treatment of Co-Occurring Disorders Toolkit*, and the *Living in Balance* core program (sessions 1–12). It is unclear whether the team has access to the full *Living in Balance* curriculum—which includes 47 sessions across three manuals. Notably, sessions 38–47 in the third manual address co-occurring disorders.	• Optimally, 50% or more of members with a substance use disorder attend at least one co-occurring disorders treatment group each month. • Staff may benefit from training in strategies to engage members in group substance use treatment.
S9	Co-Occurring Disorders Model	1 – 5 4	The team utilizes a co-occurring disorders approach grounded in the stages of change model. Staff apply a stage-wise framework to support members with co-occurring disorders, aiming to meet individuals where they are in their recovery process. While the team broadly endorses a harm reduction philosophy, some staff noted abstinence as a preferred long-term goal.	• 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.* • Provide training to staff on how interventions are more effective when

			Staff described implementing practical harm reduction strategies, including supporting transitions to less harmful substances, educating members on Narcan use and its availability, promoting safe injection practices, and working with members to reduce overall use. Motivational interviewing techniques are also used, such as linking reduced use to employment goals and encouraging members to limit use during work hours. The team emphasizes aligning treatment strategies with each member's current stage of change and encourages participation in both individual and group treatment to support recovery. Of the eight records reviewed for members with co-occurring disorders, all included treatment plans with identified substance use goals. Several progress notes referenced "IDDT" as the focus of contact. The documented co-occurring disorders group session showed staff efforts to promote member reflection, respond nonjudgmentally to substance use, and discuss member-defined goals. Some individual session notes lacked detail about the interventions provided or the information shared during the contact.	they align with a member's stage of change, i.e., a stage-wise approach. Stage-wise treatment and interventions are an essential element of the Integrated Co-Occurring Disorders Treatment model.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team includes at least four staff with lived or living psychiatric experience that share their recovery journey with members when appropriate. The two interviewed members were aware of peer staff on the team. One member reported	

			that staff with lived experience promote a more supportive and nonjudgmental engagement style.	
Total Score:		**118**		

ACT FIDELITY SCALE SCORE SHEET

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

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	3
2. No Drop-out Policy	1 - 5	5
3. Assertive Engagement Mechanisms	1 - 5	4
4. Intensity of Service	1 - 5	3
5. Frequency of Contact	1 - 5	2
6. Work with Support System	1 - 5	2
7. Individualized Co-Occurring Disorders Treatment	1 - 5	4
8. Co-occurring Disorders Treatment Groups	1 - 5	2
9. Co-occurring Disorders Model	1 - 5	4
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**4.21**	
Highest Possible Score	**5**	