ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

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 August 26 – 28, 2024, Fidelity Reviewers completed a review of the Lifewell Desert Cove 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 the Central Region of Arizona.

Lifewell Behavioral Wellness offers outpatient behavioral health, supported employment, housing, and residential services. The individuals served through the agency are referred to as *members*.

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

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

- Remote observation of an ACT team program meeting on August 28, 2024.
- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with Co-Occurring Disorders, Housing, Vocational, ACT, and Peer Support Specialists.
- Individual phone interviews with three members participating in ACT services with the team.

- Closeout discussion with the Clinical Coordinator, Lifewell Leadership, and representative(s) from the contractor with a Regional Behavioral Health Agreement (RBHA).
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system. The sample included members from the following health plan categories: Long Term Care, RBHA, Division of Developmental Disabilities, and other (Medicare, private, or other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; copy of outreach, engagement, and other contact guidelines; copies of cover pages of materials used for the provision of individual and group substance use treatment; co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and Co-Occurring Disorders Specialists; productivity report for Clinical Coordinator; and a copy of the ACT Team Brochure.

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.

<u>Summary & Key Recommendations</u>

The agency demonstrated strengths in the following program areas:

- Team Approach - 90% of members have in-person contact with more than one member of staff in a two-week period.
- Responsibility for Psychiatric Hospital Discharge Planning - The team has increased involvement in psychiatric hospital discharge planning to 100% of the ten most recent discharges.
- No Drop Out Policy - Retention of the team caseload is up to 96% in the last year.
- Individualized Co-Occurring Disorders Treatment - The team gained a Co-Occurring Disorders Specialist, increasing the provision of formal individual substance use treatment services for members with co-occurring disorders (COD).

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

- Continuity of Staffing – Optimally, turnover should be no greater than 20% over a two-year period. If not done so already, consider examining motives for resignation for exiting staff, and attempt to identify factors contributing to turnover.
- Community Based Services – Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities where challenges are more likely to occur. For members that come into the office multiple times a week, explore how to deliver those services in natural settings where members live.

- Co-Occurring Disorders Groups – On ACT teams, all staff participate in engaging members with co-occurring disorders to participate in treatment groups. Ideally, at least 50% of members diagnosed with COD attend at least one treatment group monthly.
- Co-Occurring Disorders Model – Increase the provision of training and ongoing mentoring in a co-occurring disorders treatment model to all specialists on the team. Ensure the Co-Occurring Disorders Specialists has opportunities to model skills and provide consultation, such as cross-train other specialists in developing assessment and treatment skills related to a co-occurring disorders model. Ideally, Co-Occurring Disorders Specialists attend all treatment planning meetings for members with COD to allow the opportunity to provide guidance on language and steps to address substance use disorders.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team serves 100 members with 8.45 full time equivalent (FTE) direct service staff, excluding the psychiatric prescriber and administrative staff. The team has a member to staff ratio of approximately 11:1. Staff on the team include the Clinical Coordinator, one Employment Specialist, one ACT Specialist, one Co-Occurring Disorders Specialist, one Housing Specialist, one Peer Support Specialist, one Independent Living Specialist, and two Registered Nurses.	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 – 5 5	Staff report that over a two-week period, 50% of members interact with more than one member of staff. The team utilizes a geographic zone approach to ensure members are seen weekly by staff and rotates zones weekly. Staff are assigned a caseload of approximately 12 members and are responsible for completing administrative tasks, and ensuring weekly contact is completed. Of the 10 randomly selected member records reviewed for a month period, a median of 90% received in-person contact from more than one staff in a two-week period.	
H3	Program Meeting	1 – 5 5	Per interviews with staff, the team meets in-person four days weekly and reviews all members on the roster; all staff, including the prescriber, are expected to attend on scheduled workdays.	

			During the program meeting observed, the team discussed member stages of change, housing needs, employment, inpatient or residential treatment updates, outreach attempts, natural support contact, and planned future contact. The Clinical Coordinator facilitated the meeting by announcing member names from the roster. The Clinical Coordinator did not provide clinical direction or guidance for member engagement.	
H4	Practicing ACT Leader	1 – 5 4	The Clinical Coordinator estimates providing approximately 15-20 hours of direct in-person services weekly. Reported activities include medication observations, crisis calls, and home visits. The productivity expectation for in person services for direct staff was unclear. Of the 10 records reviewed, there were seven examples of the Clinical Coordinator delivering direct services to members in the community, including home visits and transporting members to their residences after discharging from inpatient settings. Records showed engagement with natural supports, hospitals, discussions around employment, reduction of substance use, and independent living skills. *The fidelity tool does not accommodate delivery of telehealth services.* *This item is dependent on the Provider productivity expectation.*	• Optimally, the ACT CC 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 services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery.
H5	Continuity of Staffing	1 – 5	Based on the information provided, 17 staff left the team resulting in a turnover rate of 77% during the past two years. The positions with the	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the

		2	highest turnover were the Housing Specialist and Nurse positions.	therapeutic relationship between members and staff. • Continue efforts to recruit and retain experienced staff. Support staff in their specialty roles by ensuring training and guidance applicable to the specialty position is provided.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the team operated at approximately 82% of full staffing capacity. There was a total of 24 vacant positions in the last 12 months. The Housing Specialist was vacant for five months, and one Registered Nurse position was vacant for seven months.	• 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 includes one Psychiatric Nurse Practitioner to service the 100-member roster, working Tuesday through Friday, for a total of 40 hours per week. Members reported seeing the Psychiatric Nurse Practitioner once every four weeks in person at the office. According to staff, the Psychiatric Nurse Practitioner is accessible by phone, in person at the office, via email, and after-hours by phone. The Psychiatric Nurse Practitioner has no responsibilities outside the ACT team. Records indicated the provider meeting with one member in the community for a medication appointment. Records also reported inclusion of natural supports in member appointments.	
H8	Nurse on Team	1 – 5 4	The team has two Registered Nurses; one is 1 FTE and works 10-hour days, Monday through Thursday, and works exclusively with ACT members. The second nurse is temporary, and is approximately .45 FTE, and works up to six hours per day, three days per week. Staff reported	• Continue efforts to recruit and retain Nurses to ensure consistency of coverage for office-based services, as well as community-based services. Having two full time nurses is one critical ingredient of a successful ACT program.

			Nurses provide case management services, home visits, injections (both in the office and community), appointment coordination, and manage hospital admissions, discharges, and member symptoms. Nurses are accessible by phone, email, and can meet in person at the office or by phone after hours. As full members of the team, they participate in home visits, treatment planning, and daily meetings. They administer medications, take vitals, and handle medical tasks similar to those in a hospital. For complex medical cases, like managing insulin misuse in diabetic members, the Nurses take the lead and guide the team. Of the 10 records reviewed, eight showed one of the Nurses delivering services to members in the office or community. Members interviewed reported seeing the nurses at least monthly.	• Identify and find solutions to factors that may contribute to staff retention in the nursing role.
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	The team is staffed with one Co-Occurring Disorders Specialist that has been on the team for over one year and has a combination of over 10 years providing individual and group substance use treatment. Training records provided showed staff receiving 15 hours of training related to substance use treatment. The Co-Occurring Disorders Specialist does not receive regular clinical supervision from a qualified professional relating to the provision of services to individuals with co-occurring disorders.	• ACT teams are staffed with two Co-Occurring Disorders Specialists for a roster of 100 members, each with one year or more of training/experience providing substance use treatment services. • Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. On ACT teams, CODS have the capability to cross-train other staff, providing

				guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model utilized by the team.
H10	Vocational Specialist on Team	1 – 5 2	The team has one Vocational Specialist who has been working with members since 2019. Training records showed no vocational-related training completed since the last review. Currently, the Rehabilitation Specialist position is vacant.	• 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; 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. • Optimally, 100-member ACT teams are staffed with two Vocational Specialist staff. Ensure the staffing ratio aligns appropriately with the number of members on the census.
H11	Program Size	1 – 5 4	At the time of the review, the team was comprised of 9.45 FTE staff, including the Psychiatric Nurse Practitioner. Current vacant positions per the team include one Rehabilitation Specialist and one Co-Occurring Disorder Specialist. Although not identified as a vacancy, the team requires a full time second Nurse to ensure all members are provided adequate service. *This item does not adjust for the size of the member roster.*	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, a minimum of 10 direct service staff, allows the team to consistently provide diverse coverage; helps to prevent potential staff burn-out; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member.

O1	Explicit Admission Criteria	1 – 5 4	The team follows the *Mercy Care ACT Admission Criteria* to screen new referrals, and a copy was provided to reviewers. Staff reported the team receives referrals internally, from supportive level teams, and externally from hospitals and the contractor with a Regional Behavioral Health Agreement. The Clinical Coordinator conducts most initial screenings; the Employment Specialist, Co-Occurring Disorders Specialist, and Psychiatric Nurse Practitioner are also able to conduct screenings. Upon receiving an internal referral, the Clinical Coordinator reviews the member's record to confirm a qualifying diagnosis. The coordinator then explains ACT services to the potential member, addressing common misconceptions, such as the lack of immediate housing, and explains participation in services is voluntary. If the member remains interested, staff meet them in the community for further discussion and the team Psychiatric Nurse Practitioner coordinates with the referring provider. The Clinical Coordinator, Psychiatric Nurse Practitioner, and Clinical Director then review the case, with the Director making the final admission decision. Staff report leadership pressures the team to admit members in order to maintain a roster of 100 members; this prompts an urgency in admissions when the census drops below this threshold.	• ACT teams have final approval on admissions to the team, rather than agency staff.

			Staff report 5 - 10% of the current roster could step down to a lower level of care. Four percent of the member roster is comprised of members with Intellectual Developmental Disabilities (IDD) that are living in IDD housing; staff coordinate care for these members by being involved in treatment planning and staffing's. Staff report up to an additional six percent of members on the team have intellectual developmental disabilities but do not receive IDD services. Of the 10 member records reviewed, one had a diagnosis of Borderline Intellectual Functioning. An additional two member records showed Social Determinants of Health (SDOH) related Z codes that indicated problems related to education and literacy, and problems related to school.	
O2	Intake Rate	1 – 5 5	Based on the data provided and reviewed with staff, the team has an appropriate admissions rate. The month with the highest admissions during the six months prior to the review was July, with three new members added to the roster.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services and medication management, co-occurring disorders treatment, and employment support. At the time of the review, no members were receiving psychotherapy or counseling from staff on the team. The team reported approximately 25 members receive general counseling from agency assigned counselors.	• In the EBP of ACT, services are fully integrated into a single team with no, or very few, referrals to external providers. • Counseling/psychotherapy is made available to members on ACT teams and is provided by ACT staff. This staff will also act as a generalist within the team. Consider exploring options to provide counseling services to members of the ACT team, either through new or currently existing ACT staff.

			Per data provided and interviews with staff, over 10% of members reside in settings where ACT services are duplicated.	• 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.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24/7 crisis services, with the on-call phone rotating weekly among specialists and the Clinical Coordinator providing backup support. When a distressed member calls the on-call phone, staff assess the situation, attempt de-escalation, and, if needed, coordinate with the Clinical Coordinator for safety before meeting members in the community or transporting them to hospitals for further assessment. Upon admission to the team, members receive the *Desert Cove ACT Brochure* with the on-call number and staff contacts. Interviewed members reported knowing how to reach the team after hours, and experience using the on-call service in the past.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported being actively involved in member hospital admissions. The team assesses members for de-escalation and stabilization and, when possible, transports them to the office for evaluation by a Nurse or the Psychiatric Nurse Practitioner to determine next steps. If inpatient stabilization is needed, staff will transport	• ACT teams performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. • Work with each member and their support network to discuss how the team can

			members to the hospital and provide inpatient staff with current medication lists, the last psychiatric provider note, and member demographic information upon admission. Based on the data provided and reviewed with staff of the ten most recent psychiatric hospitalizations that occurred over a two-month time frame, the ACT team was directly involved in 50%. Of those admissions in which staff were not involved, members self-admitted and the team was notified afterwards. An additional member that was on court-ordered treatment was picked up by police and transported to the hospital.	support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can provide aid during admission, especially for members with a history of seeking hospitalization without team support.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported being directly involved in all psychiatric discharges. The team coordinates hospital staffing's, confirms discharge plans, and ensures members have follow-up appointments scheduled with the Registered Nurse and Psychiatric Nurse Practitioner within 48 and 72 hours, respectively. Upon discharge, staff often transport members home, assist with picking up medications, and assess the member's living situation. The team follows a five-day post-discharge protocol, which includes daily home visits or phone calls and regular in-person contacts with specialists to ensure continuity of care and prevent re-hospitalization. Discharge planning is discussed during team meetings, and the team coordinates with the Primary Care Physician as needed. Per the review of data with staff relating to the last 10 psychiatric hospital discharges that	

			occurred over a two-month period, the team was directly involved in 100% of discharges.	
O7	Time-unlimited Services	1 – 5 5	Data provided showed four members graduated from the team with significant improvement in the past 12 months. The team estimates in the next year 5-10 members will be ready to step down to a supportive team.	
S1	Community-based Services	1 – 5 3	Staff interviewed reported 80 - 90% of in-person contacts with members occur in the community. Staff reported home visits occur up to twice weekly, sometimes including medication observations. Of the three members interviewed, all reported having weekly home visits by at least two different staff members. Records reviewed show staff providing services a median of 55% of the time in the community. Documented services include home visits, independent living skills training, transportation to appointments, 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. • Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts.
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had five members leave the program in the past year. The team retained 96% of the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff reported the team makes at least four attempts weekly, over eight weeks, to reconnect with members who have lost contact. Two attempts are conducted in the community and two via electronic means (phone or email). Outreach duties rotate among staff weekly and involve visiting the member's last known address, frequented locations, and homeless shelters. The team also reaches out to natural	

			supports, guardians, hospitals, probation officers, jails, and other relevant contacts. During the program meeting observed natural support contact was discussed regarding 41 members, in attempts to update, coordinate and/or re-engage members in services. Reviewers received a copy of the team's contact guidelines, which detailed standards for the frequency and duration of member contact. Records reviewed showed the team completing weekly outreach in the community, however no documentation of electronic attempts to engage or locate members.	
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 spends in-person with members per week is approximately 51 minutes. The member with the highest weekly average being 119 minutes of service. The member with the lowest being 12 minutes.	• Increase the duration of service delivery to members. ACT teams provide an average of two (2) or more hours of in-person services per week to help members with serious symptoms maintain and improve functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms. • Ensure the team is assisting members in working on recovery goals as identified. By using *motivational interviewing*, and other techniques, the team can assist members to identify meaningful recovery goals and then offer the supports and services to members to reach those goals. • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. Documented

			The fidelity tool does not accommodate delivery of telehealth services.	service time is significantly higher for some members than for others.
S5	Frequency of Contact	1 – 5 3	Of the 10 records randomly sampled, staff provided a median frequency of 2.88 in-person contacts to members per week. The record with the highest frequency was 5.25, and the lowest record included .75 contacts per week.	• Improved outcomes are associated with frequent contact. Members of ACT teams are typically not successful with traditional case management services and often require more frequent contact to assess 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 and align with members' treatment goals.
S6	Work with Support System	1 – 5 3	Data provided indicates 43 members have natural supports (non-paid supports). The team tracks and documents contacts within the member record. Staff reported weekly contact with most natural supports typically occurs during home visits; some natural support contact occurs via the phone. During the program meeting, natural support contact was discussed for most members with identified natural supports. Records reviewed showed an average of .70 contacts with members' natural supports during a 30-day period.	• Assist members in developing a natural, community-based support system. Active participation with peer run programs are 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. • Continue efforts to engage members' natural support systems as key contributors to member recovery team. Consider the role of staff to model recovery language and provide suggestions to family members and other natural supports how they can support member care.

S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	Based on the data provided and discussed with staff, there are 58 members on the roster with co-occurring disorders. Of the 10 records reviewed, half were members with co-occurring disorders. Among these, one record showed evidence of an individualized substance use treatment session occurring once during a 30-day period. Staff reported that approximately 50% of identified members receive at least one structured individual substance abuse treatment session. Staff reported these sessions are 25 to 30 minutes long.	• Continue efforts to increase the time spent in individual treatment sessions and increase the number of members engaged so that the average time is 24 minutes, or more, per week across the group of members with co-occurring disorders. • All staff on ACT teams engage members with co-occurring disorders to consider participating in substance use treatment. Explore training on strategies to engage members.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 2	Staff interviews revealed that the team provides one co-occurring disorders treatment group each week, led by the Co-Occurring Disorders Specialists. While a curriculum is in place, the sessions are adjusted based on the number of attendees and their specific needs, focusing on member attitudes and current challenges. The curriculum serves as a starting point for the group. A review of sign-in sheets from the month prior to the review showed five unique members with co-occurring disorders (8.6%) participated in these groups.	• 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 percent or more of applicable members participate in co-occurring disorders group monthly. • Consider offering groups so that at least one is structured for members in earlier stages, and one is available for members in later stages of recovery. Interventions should align with a stage-wise approach.
S9	Co-Occurring Disorders Model	1 – 5 3	Staff reported familiarity with harm reduction strategies, motivational interviewing techniques, and the utilization of a person-centered approach to support members with co-occurring disorders. Staff do not refer members to peer-run meetings but do refer to detoxification programs when members are using methamphetamine and fentanyl. Staff reported	• 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.*

			the team receives online training on co-occurring disorders up to twice annually and has regular opportunities for additional education and training. The Co-Occurring Disorders Specialist will occasionally provide guidance and education regarding best practices but is not responsible for providing the team with formal co-occurring disorders training. Staff reported the Co-Occurring Disorders Specialist shares when a member's stage of change is fluctuating and offers advice how to engage or approach the member. During interviews most staff struggled to match stage-wise treatment interventions with the appropriate stage of change. Among the five member records reviewed for individuals identified with co-occurring disorders, one included a treatment plan with specific interventions detailing how the team would support the member's progress toward recovery goals. Most of the remaining treatment plans were written in traditional clinical language rather than focusing on specific supportive steps toward recovery.	• Support Co-Occurring Disorders Specialist staff to provide the team with mentoring and modeling of an integrated co-occurring disorders model. Providing daily support to the team in best practices may improve the level of engagement in services by members.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team includes at least two staff that have personal lived or living psychiatric experience and, when appropriate, share their recovery journeys with members. Staff interviews revealed the peer perspective enhances the team's understanding of member needs. Members interviewed were not aware of peers on the team. One member indicated it would be helpful to have a peer on staff.	

Total Score:	109	

ACT FIDELITY SCALE SCORE SHEET

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

6.	Responsibility for Hospital Discharge Planning	1-5	5
7.	Time-unlimited Services	1-5	5
Nature of Services		Rating Range	Score (1-5)
1.	Community-Based Services	1-5	3
2.	No Drop-out Policy	1-5	5
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	3
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	3
10.	Role of Consumers on Treatment Team	1-5	5
Total Score		**3.89**	
Highest Possible Score		**5**	