Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT **Provision of Assertive Community Treatment to MHRS Adult Consumers**		
POLICY NUMBER **DBH Policy 340.6**	**DATE** MAY 08 2014	**TL#** 248

Purpose. To delineate policies, procedures, and practice guidelines in the implementation of Assertive Community Treatment (ACT) to adult consumers in Mental Health Rehabilitation Services (MHRS).

This revision adopts the policy from the former Department of Mental Health, now merged into the new Department of Behavioral Health, in accordance with the DBH Establishment Act of 2013.

Applicability. Applies to the Department of Behavioral Health (DBH) MHRS providers who serve adults. DBH and contractors are responsible for compliance with this policy

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices.

Effective Date. This policy is effective immediately.

Superseded Policy. This policy replaces DMH Policy 340.6A, Provision of Assertive Community Treatment (ACT) to Adult Consumers, signed December 9, 2009.

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

5/8/14

Stephen T. Baron
Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH	Policy No. 340.6	Date MAY 0 8 2014	Page 1
	Supersedes: DMH Policy 340.6A, Provision of Assertive Community Treatment to Adult Consumers, dated December 9, 2009		

Subject: Provision of Assertive Community Treatment to Adult MHRS Consumers

1. **Purpose**. To delineate policies, procedures, and practice guidelines in the implementation of Assertive Community Treatment (ACT) to adult consumers in Mental Health Rehabilitation Services (MHRS).

2. **Applicability**. Applies to Department of Behavioral Health (DBH), MHRS providers who serve adults, and ACT Providers.

3. **Authority**. Department of Behavioral Health Establishment Act of 2013 and Title 22A, DCMR, Chap. 34, Mental Health Rehabilitation Services Provider Certification Standards (MHRS).

4. **Definitions**.

4a. **Assertive Community Treatment (ACT)**. Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness. ACT services are provided to consumers in accordance with the IRP. ACT teams involve specific and dedicated staff to consumer ratios. Service coverage by the ACT team is required to have specific program hours but to be available for crisis services 24 hours per day, seven days per week. At least sixty percent (60%) of services are required to be provided to the consumer in non-office settings in the community.

As with all DBH services, potential ACT consumers must be: (1) willing to accept services, (2) have a guardian in order to sign the consumer into services, or (3) be a committed outpatient.

4b. **ACT Providers**. Agencies certified by DBH to provide ACT services, consistent with the MHRS Standards and the Department of Behavioral Health Establishment Act of 2013, and the Mental Health Consumers' Rights Protection Act.

4c. **ACT Team**. The community-based inter-disciplinary team of qualified practitioners and other staff involved in providing ACT services to a consumer. Most services are provided in community-based settings, not in the office.

4d. **IRP**. Individualized Recovery Plan, as defined by the MHRS Standards.

4e. **ISSP**. Individualized Service Specific Plan, as defined by the MHRS Standards.

4f. **LOCUS**. "Level of Care Utilization System" adopted by DBH for assessing the level of care of adults with mental illness.

4g. **Dartmouth ACT Scale (DACTS)**. This scale has been developed to measure the adequacy of implementation of ACT programs. The scale items fall into three (3) categories: human resources (structure and composition), organizational boundaries, and nature of services.

5. **Policy**.

5a. DBH will utilize ACT services to support adult consumers with serious and persistent mental illness who meet the ACT eligibility criteria.

5b. DBH will respect consumer strengths and negotiable preferences in the delivery of ACT services, and develop interventions that could best facilitate consumer recovery. Services will primarily be provided at the consumer's residence or other community settings.

5c. DBH will adhere to the Dartmouth ACT Scale (DACTS) in order to measure the adequacy of ACT implementation and identify what needs to be addressed toward quality ACT services. ACT startup teams will implement a baseline fidelity assessment using the Dartmouth Fidelity Scale.

5d. The requirements outlined in the ACT Practice Guidelines (Exhibit 1) will be followed to qualify for ACT services. The Level of Care requirement must be a LOCUS score of 20-22 or higher to initially receive ACT services (LOCUS Worksheet - Exhibit 2) and a LOCUS Score of 19 or above for reauthorization.

5e. Consumers who are assessed to be needing ACT but refuse services will be assisted towards receiving the appropriate care.

6. **Responsibilities**. In order to provide services to adults with serious and persistent mental illness,

6a. Behavioral Health Providers must complete the ACT Referral Form (Exhibit 3) with accompanying documentation as indicated on the form.

6b. The DBH ACT Coordinator/designee must review the referral form; provide authorization for ACT services, if appropriate; assign the consumer to an ACT Team; and ensure that there compliance oversight of this policy by DBH.

6c. Core Services Agencies (CSAs) must work collaboratively with the consumer and the ACT Team to ensure continuity of care upon admission, reactivation, and discharge from ACT services.

6d. All "ACT Providers" must:

(1) Implement the required activities in the DBH service authorization manual and the MHRS Certification Standards including all MHRS Bulletins and any updates that may be issued by DBH relating to the provision of ACT services.

(2) Accept and engage all consumers authorized by DBH for ACT services within forty-eight (48) hours of assignment to an ACT Team.

(3) Hold team meetings daily to review and discuss consumer progress, the previous day's activities, assignment of new activities, and other ongoing concerns.

(4) Screen for co-occurring disorders and initiate an integrated assessment and treatment intervention as indicated.

(5) Provide services twenty four hours, seven days a week (24/7), including after hours, on weekends and holidays. At least sixty percent (60%) of services to the consumer must be provided in the community rather than the provider's office setting.

(6) Provide the full array of services and supports required by enrolled consumers to support mental health rehabilitation and stabilization.

(7) Ensure continuity of services for persons entering or leaving ACT as specified in Section 8 of this policy.

(8) Attend monthly DBH ACT Provider meetings.

(9) Submit monthly and other programmatic reports as deemed necessary by DBH.

(10) Engage with the consumer to identify suitable and meaningful daily activities and facilitate the consumer's participation in those activities.

(11) Ensure that human resources (structure and composition), organizational boundaries, and nature of services is adequate in implementing ACT standards.

7. **Authorization for ACT Services**.

Prior authorization from DBH is required for enrollment in ACT and re-authorization is required for continued treatment. The DBH ACT Coordinator must approve initial, reactivation, and discharge requests, as appropriate. All requests for, and changes to ACT services MUST be submitted through the Provider Connect event screens. Any questions regarding ACT must be directed to the DBH ACT Coordinator who has the authority to address issues and resolve problems with the authorization for provision of ACT services.

In cases where a former ACT consumer has not received ACT services for more than thirty (30) days, the CSA must contact the DBH ACT Coordinator/designee prior to completing any electronic submission in Provider Connect for reactivation of ACT services.

8. **Continuity of Care for ACT Consumers**.

8a. **Upon Initial Acceptance into ACT Services**.

(1) There must be a thirty (30) day transition period allowing for a "shared" caseload between the consumer's CSA and the ACT Team, where the CSA community support team must continue to provide some support services while the ACT Team is beginning to engage the consumer. This may be renewed on a case by case basis based on medical necessity and clinical presentation.

(2) The services to be provided during this thirty (30) day transition period must be documented in the consumer's IRP and ISSP, which must be coordinated by the CSA and jointly developed by the consumer, the CSA community support team, and the ACT Team. Outcomes to be achieved by participating in ACT must be clearly identified in the goals and interventions on the IRP and supported in an ISSP.

- The CSA and ACT Team must jointly meet with the consumer face to face a minimum of three (3) times a week during the transition period. The number of contacts may be adjusted on a case by case basis. Some consumers may require more contact, and negotiation may be made to reduce contacts if transition is going smoothly.

(3) If not previously contacted by the ACT Team or CSA, the DBH ACT Coordinator/designee must follow-up on the consumer's status/disposition on or before the 30th day of enrollment in ACT.

8b. **Upon Discharge from ACT Services**.

(1) For all consumers being referred from ACT services to a designated CSA, there must be a thirty (30) day transition period allowing for a "shared" caseload (this may be renewed on a case by case basis based on medical necessity and clinical presentation). During the transition period, the ACT Team must continue to provide some services and supports while the CSA community support team is engaging the consumer.

(2) The services to be provided during this thirty (30) day transition period must be documented in the consumer's IRP and ISSP and jointly developed by the consumer, the CSA, and the ACT Team.

9. **Training**. DBH and provider staff will receive training in the implementation of ACT fidelity assessments (Exhibit 4) to sustain on-going fidelity monitoring and quality improvement efforts.

10. **Sanction for Non-Compliance**. Non-compliance with the requirements of this policy must result in serious and appropriate action in accordance with DBH policies and rules. See Title 22A DCMR Chapter 34, Mental Health Rehabilitation Services Provider Certification Standards.

11. **Inquiries**. Questions related to this policy should be addressed to the DBH ACT Coordinator.

12. **Exhibits**.

Exhibit 1 ACT Practice Guidelines
Exhibit 2 LOCUS Worksheet 2000
Exhibit 3 ACT Referral Form
Exhibit 4 ACT Fidelity Scale (DARMOUTH)

Approved By:

Stephen T. Baron
Director, DBH

5/8/14

(Signature) **(Date)**

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Behavioral Health
Assertive Community Treatment
PRACTICE GUIDELINES

Service Definition

Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness. ACT services are provided to consumers in accordance with the IRP. ACT teams involve specific and dedicated staff to consumer ratios. Service coverage by the ACT team is required to have specific program hours but to be available for crisis services 24 hours per day, seven days per week. At least sixty percent (60%) of services are required to be provided to the consumer in non-office settings in the community.

I. Admission Guidelines

Factors Required in ACT Referrals

1. Consumers have an intractable, serious and persistent mental illness. Mental illness may co-occur with substance use disorder)

A. One or more items from #2-7 below

2. High use of acute psychiatric hospitalization (two or more admissions per year) or F/EMS contacts; CPEP/mobile crisis visits; crisis stabilization services.

3. Co-Occurring substance use disorders of greater than 6 months.

4. Recent history of criminal justice involvement (arrests or incarcerations) within the past 6 months.

5. Chronically homeless (one year continuously homeless or 4 episodes of homelessness in 3 years) or residing in substandard housing.

6. Residing in an inpatient setting for more than 3 months or supervised community residence but clinically assessed to be able to live more independently with increased community-based services.

7. Has documented inability to sustain involvement with or remain engaged in traditional office-based services.

B. One or more items from #1-3 below

1. Significant difficulty consistently performing the range of daily living tasks required to live in the community.

2. Significant difficulty maintaining consistent employment.

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3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing, or being burglarized or robbed due to mental health instability).

C. Level of Care Assessment

Locus Score of 20 - 22 or higher for initial assessment and 19 or above for re-authorization.

Information and Documentation Required for Referral

Multi-Axial Diagnosis
Psychosocial Summary
ACT Referral Form
Locus Score

II. Referral Process

1. Consumers requiring ACT services may be referred by their existing Core Services Agency (CSA), by themselves, or a personal advocate such as family member, friend, Institution or community based agency.

2. A CSA is required to enter an authorization request into their Ecura system and submit the above listed information to the ACT Coordinator.

3. All other referral sources are required to compile the above listed information and submit to the ACT Coordinator. However, the ACT Coordinator may need to facilitate obtaining the information through making referrals to the Homeless Outreach Program ("HOP"), mobile crisis, or other mechanisms to get the information packet completed.

4. Once the information is available to the ACT Coordinator, and authorization is approved, the consumer will be assigned to the ACT team by the ACT Coordinator or designee. The team is required to follow up and begin delivering services within 48 hours of referral per MHRS standards.

5. CSAs will be responsible for producing appropriate documentation to the ACT team and provide a 30 day transition period. This documentation includes: most recent doctor's notes including doctor's orders, recent progress notes, psychiatric and medical assessments and details about matters which may need to be addressed immediately. This information should be provided within 48 hours of referral.

6. The transition process should also include a face to face meeting between both clinical teams and the consumer. This meeting may also include the referral source if that is not the same as the original clinical team.

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7. ACT teams themselves DO NOT have the authority to deny authorizations or service delivery once the consumer has been authorized and assigned to the team.

8. Notification Process: The source of the referral (consumer, CSA, advocate etc.) will be notified of the decision to refer the consumer for ACT services within 48 hours of receipt of referral.

9. Grievance Process: The referral source, the consumer, or the ACT service may grieve the decision in the following ways:

1) Request a review by the ACT Coordinator.
2) Request an official review by the DBH Chief Clinical Officer or designee.
3) File a grievance through the official grievance process.

III. Discharge Process

Consumers must be approved by the ACT Coordinator for discharge from ACT. ACT consumers will stay on the ACT rolls regardless of hospitalization.

Updated April 2014 (DMH changed to DBH in 2014)

Contributors to the document: All ACT team leaders, ULS, Washington Legal Clinic, Miriam's Kitchen, DBH Staff: HOP staff, Alvin Hinkle, Eugene Wooden, Lisa Bullock, Jana Berhow, AHL, and ACT stake holders.

MAY 0 8 2014

DBH Policy 340.6
Exhibit 2

LOCUS WORKSHEET
VERSION 2000

Rater Name: Date:

Please check the applicable rating within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using the Placement Grid or the Decision Tree.

I. Risk of Harm ( ) 1. Minimal Risk of Harm ( ) 2. Low Risk of Harm ( ) 3. Moderate Risk of Harm ( ) 4. Serious Risk of Harm ( ) 5. Extreme Risk of Harm Score: ____	IV – B. Recovery Environment – Level of Support ( ) 1. Highly Supportive Environment ( ) 2. Supportive Environment ( ) 3. Limited Support in Environment ( ) 4. Minimal Support in Environment ( ) 5. No Support in Environment Score: ____
II. Functional Status ( ) 1. Minimal Impairment ( ) 2. Mild Impairment ( ) 3. Moderate Impairment ( ) 4. Serious Impairment ( ) 5. Severe Impairment Score: ____	V. Treatment & Recovery History ( ) 1. Full Response to Treatment & Recovery ( ) 2. Significant Response to Treatment & Recovery ( ) 3. Moderate Response to Treatment & Recovery ( ) 4. Poor Response to Treatment & Recovery ( ) 5. Negligible Response to Treatment & Recovery Score: ____
III. Co-Morbidity ( ) 1. Minimal Co-Morbidity ( ) 2. Mild Co-Morbidity ( ) 3. Moderate Co-Morbidity ( ) 4. Serious Co-Morbidity ( ) 5. Severe Co-Morbidity Score: ____	IV. Engagement ( ) 1. Optimal Engagement ( ) 2. Positive Engagement ( ) 3. Limited Engagement ( ) 4. Minimal Engagement ( ) 5. Unengaged Score: ____
IV-A. Recovery Environment – Level of Stress ( ) 1. Low Stress Environment ( ) 2. Mildly Stressful Environment ( ) 3. Moderately Stressful Environment ( ) 4. Highly Stressful Environment ( ) 5. Extremely Stressful Environment Score: ____	**COMPOSITE SCORE:** **Level of Care Recommendation:**

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Behavioral Health
Assertive Community Treatment

REFERRAL FORM

Service Definition

Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness. ACT services are provided to consumers in accordance with the IRP. ACT teams involve specific and dedicated staff to consumer ratios. Service coverage by the ACT team is required to have specific program hours but to be available for crisis services 24 hours per day, seven days per week. At least sixty percent (60%) of services are required to be provided to the consumer in non-office settings in the community.

Referral Requirements: Please include the following documents in this packet: Referral Form, Locus Worksheet, psychosocial summary.

I. Demographic Information

Referring Agency: Name/Contact Name: Phone #:

Referring Agency:

Consumer's Name: Aliases:

Also known as (Other names/aliases): _____

DOB: SSN: ECURA #:

Current Address/Shelter:

Other Locations the Consumer frequents:

II. LINKAGE INFORMATION

Current DBH-CSA:

CSW Name: Phone #:

Last time seen by Referring Agent/Frequency of Contact:

Other providers/individuals:

Name and Phone # of Guardian, if applicable:

DBH Legal Status (√): ( ) CMOP ( ) CMIP ( ) Voluntary; ( ) Other Please explain:

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Department of Behavioral Health
Assertive Community Treatment

REFERRAL FORM

III. ACT CRITERIA

Criteria I. Mental Health Diagnosis/Multi-Axial Diagnosis

Has this adult consumer been diagnosed with serious and persistent mental illness?
( )YES ( )NO

Criteria A. Evidence of clinical or life crises (Please check which of the following apply and provide details)(Must check at least one of the following.)

( ) High use of acute psychiatric hospitalization (Two or more admissions per year) or F/EMS contacts; CPEP/Mobile crisis visits; Crisis Stabilization services.

( ) Co-occurring substance abuse disorders of greater than 6 months.

( ) History of criminal justice involvement (Arrests or incarcerations) within the past 6 months.

( ) Chronically homeless (One year continuously homeless or 4 episodes of homelessness in 3 years) OR residing in substandard housing.

( ) Residing in an inpatient setting for more than 3 months or supervised community residence but clinically assessed to be able to live more independently with increased community-based services

( ) Documented inability to sustain involvement with or remain engaged in traditional office-based services.

Criteria B. Activities of Daily Living (Please check which of the following apply and provide details. Must check at least one of the following)

( ) Significant difficulty consistently performing the range of daily living tasks required to live in the community.

( ) Significant difficulty maintaining consistent employment.

( ) Significant difficulty maintaining a safe living situation (e.g. Repeated evictions or loss of housing, or being burglarized or robbed due to mental health instability)

Criteria IV. Locus Score _____(For new Referrals locus score must be within the range of **20-22** or higher, for reauthorization locus must be 19 or higher) (Please Attach Locus Worksheet)

Criteria V. Psychosocial Summary (Please Attach)

Assertive Community Treatment Fidelity Scale (DARTMOUTH)

Program_____ Respondent #_____ Role_____ Interviewer_____ Date_____

CRITERION		RATINGS / ANCHORS				
HUMAN RESOURCES: STRUCTURE & COMPOSITION		**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
H1	SMALL CASELOAD: Client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	11 - 20	10 clients/clinician or fewer
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 36%.	37 - 63%.	64 - 89%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.
H3	PROGRAM MEETING: Program meets frequently to plan and review services for each client.	Program service-planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.
H5	CONTINUITY OF STAFFING: Program maintains same staffing over time.	Greater than 80% turnover in 2 years.	60-80% turnover in 2 years.	40-59% turnover in 2 years.	20-39% turnover in 2 years.	Less than 20% turnover in 2 years.
H6	STAFF CAPACITY: Program operates at full staffing.	Program has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	80-94%	Program has operated at 95% or more of full staffing in past 12 months.
H7	PSYCHIATRIST ON STAFF: There is at least one full-time psychiatrist per 100 clients assigned to work with the program.	Program for 100 clients has less than .10 FTE regular psychiatrist.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	.70-.99 FTE per 100 clients	At least one full-time psychiatrist is assigned directly to a 100-client program.
H8	NURSE ON STAFF: There are at least two full-time nurses assigned to work with a 100-client program.	Program for 100 clients has less than .20 FTE regular nurse.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client program.
H9	SUBSTANCE ABUSE SPECIALIST ON STAFF: A 100-client program	Program has less than .20 FTE S/A	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year S/A training or

	includes at least two staff members with 1 year of training or clinical experience in substance abuse treatment.	expertise per 100 clients.				supervised S/A experience.
H10	VOCATIONAL SPECIALIST ON STAFF: The program includes at least two staff members with 1 year training/experience in vocational rehabilitation and support.	Program has less than .20 FTE vocational expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.
H11	PROGRAM SIZE: Program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.	Program has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	7.5 - 9.9	Program has at least 10 FTE staff.
	ORGANIZATIONAL BOUNDARIES					
O1	EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined mission but the admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most referrals.	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	The program actively recruits a defined population and all cases comply with explicit admission criteria.
O2	INTAKE RATE: Program takes clients in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 clients/month.	13 -15	10 - 12	7 - 9	Highest monthly intake rate in the last 6 months no greater than 6 clients/month.
O3	FULL RESPONSIBILITY FOR TREATMENT SERVICES: In addition to case management, program directly provides psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.	Program provides no more than case management services.	Program provides one of five additional services and refers externally for others.	Program provides two of five additional services and refers externally for others.	Program provides three or four of five additional services and refers externally for others.	Program provides all five of these services to clients
O4	RESPONSIBILITY FOR CRISIS SERVICES: Program has 24-hour responsibility for covering psychiatric crises.	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program	Program is available by telephone, predominantly in consulting role.	Program provides emergency service backup; e.g., program is called, makes	Program provides 24-hour coverage

			clients.		decision about need for direct program involvement.	
O5	RESPONSIBILITY FOR HOSPITAL ADMISSIONS: Program is involved in hospital admissions.	Program has involvement in fewer than 5% decisions to hospitalize.	ACT team is involved in 5% - 34% of admissions.	ACT team is involved in 35% - 64% of admissions.	ACT team is involved in 65% - 94% of admissions.	ACT team is involved in 95% or more admissions.
O6	RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: Program is involved in planning for hospital discharges.	Program has involvement in fewer than 5% of hospital discharges.	5% - 34% of program client discharges are planned jointly with the program.	35 - 64% of program client discharges are planned jointly with the program.	65 - 94% of program client discharges are planned jointly with the program.	95% or more discharges are planned jointly with the program.
O7	TIME-UNLIMITED SERVICES (GRADUATION RATE): Program rarely closes cases but remains the point of contact for all clients as needed.	More than 90% of clients are expected to be discharged within 1 year.	From 38-90% of clients are expected to be discharged within 1 year.	From 18-37% of clients are expected to be discharged within 1 year.	From 5-17% of clients are expected to be discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.
	NATURE OF SERVICES					
S1	COMMUNITY-BASED SERVICES: Program works to monitor status, develop community living skills in the community rather than the office.	Less than 20% of face-to-face contacts in community.	20 - 39%.	40 - 59%.	60 - 79%.	80% of total face-to-face contacts in community
S2	NO DROPOUT POLICY: Program retains a high percentage of its clients	Less than 50% of the caseload is retained over a 12-month period.	50- 64%.	65 - 79%.	80 - 94%.	95% or more of caseload is retained over a 12-month period
S3	ASSERTIVE ENGAGEMENT MECHANISMS: As part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., probation/parole, OP commitment) as indicated and as available.	Program passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients.	Program attempts outreach and uses legal mechanisms only as convenient.	Program usually has plan for engagement and uses most of the mechanisms that are available.	Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.
S4	INTENSITY OF SERVICE: High total amount of service time as needed.	Average of less than 15 min/week or less of face-to-face contact per client.	15 - 49 minutes / week.	50 - 84 minutes / week.	85 - 119 minutes / week.	Average of 2 hours/week or more of face-to-face contact per client.
S5	FREQUENCY OF CONTACT: High	Average of less than	1 - 2 / week.	2 - 3 / week.	3 - 4 / week.	Average of 4 or more face-

	number of service contacts as needed	1 face-to-face contact / week or fewer per client.				to-face contacts / week per client.
S6	WORK WITH INFORMAL SUPPORT SYSTEM: With or without client present, program provides support and skills for client's support network: family, landlords, employers.	Less than .5 contact per month per client with support system.	.5-1 contact per month per client with support system in the community.	1-2 contact per month per client with support system in the community.	2-3 contacts per months per client with support system in the community.	Four or more contacts per month per client with support system in the community.
S7	INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT: One or more members of the program provide direct treatment and substance abuse treatment for clients with substance use disorders.	No direct, individualized substance abuse treatment is provided by the team.	The team variably addresses SA concerns with clients; no formal, individualized SA treatment provided.	While the team integrates some substance abuse treatment into regular client contact, they provide no formal, individualized SA treatment.	Some formal individualized SA treatment is offered; clients with substance use disorders spend less than 24 minutes/week in such treatment.	Clients with substance use disorders spend, on average, 24 minutes / week or more in formal substance abuse treatment.
S8	DUAL DISORDER TREATMENT GROUPS: Program uses group modalities as a treatment strategy for people with substance use disorders.	Fewer than 5% of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.	5 - 19%	20 - 34%	35 - 49%	50% or more of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.
S9	DUAL DISORDERS (DD) MODEL: Program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	Program fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Program uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for persuasion of clients in denial or who don't fit AA.	Program uses mixed model: e.g., DD principles in treatment plans; refers clients to persuasion groups; uses hospitalization for rehab.; refers to AA, NA.	Program uses primarly DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalize for rehab. nor detox except for medical necessity; refers out some s/a	Program fully based in DD treatment principles, with treatment provided by program staff.

					treatment.	
S10	ROLE OF CONSUMERS ON TREATMENT TEAM: Consumers are involved as members of the team providing direct services.	Consumers have no involvement in service provision in relation to the program.	Consumer(s) fill consumer-specific service roles with respect to program (e.g., self-help).	Consumer(s) work part-time in case-management roles with reduced responsibilities.	Consumer(s) work full-time in case management roles with reduced responsibilities.	Consumer(s) are employed full-time as clinicians (e.g., case managers) with full professional status.