ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: October 27, 2017

To: Laryssa Lukiw, ACT Varsity Clinical Coordinator
Dr. Amanda Troutman
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AHCCCS Fidelity Reviewers

Method

On October 3-4, 2017, T.J. Eggsware and Annette Robertson completed a review of the Partners in Recovery MetroCenter (Metro) Varsity Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

Partners in Recovery (PIR) serves individuals with Serious Mental Illness (SMI) through multiple locations in Maricopa County: Metro, West Valley, Hassayampa, East Valley, Arrowhead, Gateway, and West Indian School. There are two ACT teams located at the Metro campus, Omega and Varsity; the latter was the focus of this review. The team experienced turnover at multiple positions since the last review, including the Clinical Coordinator (CC) which remained vacant the four months preceding this review.

The individuals served through the agency are referred to as *members, patients* and *clients*, but for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

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

- Observation of a daily ACT morning meeting on October 3, 2017;
- Interviews with four members receiving ACT services: one group interview with two members, and two individual interviews;
- Interview with the Metro Omega ACT team CC, who provided coverage and guidance to the Varsity ACT team during the CC vacancy, with the new Varsity team CC (who was recently promoted from within the team) sitting in on the interview;
- Individual interviews with lead Substance Abuse Specialist (SAS), Independent Living Specialist (ILS) and Employment Specialist (ES);
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of documents and resources such as: ACT team roster, Varsity ACT Morning Meeting log, resumes for Vocational and SAS positions, group supervision information, and *Assertive Community Treatment (ACT) Operational Manual* (rev. June 2017), *The ACT Eligibility Screening Tool*, *ACT Team Eligibility Criteria*, and *ACT Exit Criteria Screening Tool* developed by the Regional Behavioral Health

Authority (RBHA).

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The ACT team meets four days a week to discuss each member of the team. During the meeting observed, there was evidence of staff taking the primary role in implementing services related to their specialty positions, as well as encouragement from team leadership for specialty staff to provide targeted support to address member needs in relation to the specialty staff roles on the team.
- The team is staffed with two SASs: a Lead SAS who is a Licensed Master Social Worker (LMSW) and has been with the team about five years, and a SAS who joined the team in July 2017 with over ten years prior experience providing substance use treatment.
- The team provides crisis coverage to members 24 hours a day, seven days a week.
- Based on staff report, no members closed due to any of the following reasons: refusing or terminating services, moving from the geographic area without referral, or due to the team determining the member could not be served.

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

- The team experienced disruption in staff retention, with just under 63% in the past two years, and multiple staff who filled the positions of CC, Nurse, Housing Specialist (HS), and Peer Support Specialist (PSS) during a two year timeframe. Three positions currently remain vacant. Attempt to screen and orient potential ACT staff so they are prepared to deliver ACT services. Examine employees' motives for resignation, and consider using tools (e.g., employee exit interviews) to identify trends in employee turnover including the PSS, one Nurse, and the Rehabilitation Specialist (RS) position due to the recent promotion of the staff to the role of the CC.
- The results of the record review indicated some members had contact with less than two different staff over a two week period. Reassess the team strategy for member face-to-face contact with multiple staff with a goal of more varied staff contacts with members.
- Engage ACT members who experience co-occurring challenges to attend substance use treatment through the team. Ensure all staff are trained in co-occurring interventions that align with stages of treatment, and review the team approach to tracking stage of treatment so interventions can be planned and effectively implemented.
- Engage informal/natural supports in member treatment.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of review there were nine full-time staff working on the ACT team: a Psychiatrist, a Nurse, an ES, two SASs, an ILS, a HS, an ACT Specialist, and the CC who transitioned into the position on October 2, 2017 from her prior role as RS. The team has access to a float staff (titled Senior ACT Specialist) who also provides coverage to other PIR teams, and though it was estimated he spends approximately 50% of his time providing services to ACT Varsity members, few notes attributable to him were located in ten member records reviewed, so the position was not factored into this item. Excluding the Psychiatrist, the member-to-staff ratio was nearly 12:1 for the 93 member program.	• Recruit and hire qualified staff who are oriented and prepared to provide ACT services.
H2	Team Approach	1 – 5 3	The member record review revealed that around 60% of members had face-to-face contact with more than one staff member, in a two week period, which was consistent with one staff member's estimate. Members interviewed who reside in congregate settings reported more frequent contact with ACT staff than those in independent residences.	• Ensure that ACT staff are familiar and work with all members; 90% or more of members should have face-to-face contact with more than one staff in any two week period.
H3	Program Meeting	1 – 5 5	The ACT team meets four days a week – Tuesday through Friday – to discuss each member of the team. The team Psychiatrist attends each meeting, as does the Nurse and other staff on the days they are scheduled to work. During the meeting observed, there was evidence of staff taking the primary role in implementing services related to their specialty positions, including: assisting members to enhance independent living skills, connecting members with resources to obtain and sustain housing, assisting members with	

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			vocational activities, and substance use treatment.	
H4	Practicing ACT Leader	1 – 5 1	The CC transitioned from her role as RS on October 2, 2017, and as such, there was no direct service time provided by the CC in that role prior to the review. Per report, other administrators and a CC from another ACT team at the clinic shared coverage responsibilities; however, only one note attributable to any of those staff identified was located in ten member records reviewed, with no evidence of direct services to members.	• The CC should provide direct service to members with a goal of 50% of her overall time. Sharing in the provision of community-based services will allow for opportunities to observe, train, and mentor other staff.
H5	Continuity of Staffing	1 – 5 2	The team experienced just under 63% turnover, with 15 staff who left the team in the past two years. The turnover included one CC who was promoted to the position of Clinical Director at the clinic, and three other staff who filled the position of CC. Multiple staff also filled and left the positions of Nurse, HS, and PSS during the two year timeframe. When asked about the causes for staff turnover, one staff cited that some new hires may not be fully oriented to the expectations of ACT (e.g., hours of service outside the hours of 8:00 a.m. to 5:00 p.m.) during the interview and hiring process, and another staff reported some attrition was due to the fast pace of ACT services.	• Attempt to screen and orient potential ACT staff to assess their preparedness to deliver ACT services. Examine employees' motives for resignation, and consider using tools (such as employee exit interviews) to identify causes for employee turnover. This may be an area of further ongoing provider, clinic, and system review. ACT teams should experience turnover no greater than 20% over a two year period in order to support the therapeutic relationship and mitigate disruptions in services provided to members.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team operated at approximately 88% of full staffing capacity. The team did not have a full-time assigned PSS or CC for four of the last 12 months.	• Fill vacant positions as soon as possible to ensure continuity of care for members.
H7	Psychiatrist on Team	1 – 5 4	The ACT team has a one assigned Psychiatrist. The Psychiatrist works four, ten-hour days and attends ACT Varsity morning meetings four days a week. It was also reported that she provides backup support to other teams, which accounted to about 5% of her time. However, staff reported that the Psychiatrist is accessible when needed.	• Though the backup provided to other teams accounts for a small amount of her time, optimally the Psychiatrist should provide services only to the ACT Varsity members.

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H8	Nurse on Team	1 – 5 3	The team currently has one full-time Nurse, primarily assigned to office-based duties. The second Nurse position will provide community-based services. The Nurse attends team morning meetings three days a week, and staff reported he was accessible. The Nurse may be called on to see members for other teams, but staff reported that about 95% of his time is spent providing services to ACT Varsity members.	• Add a second full-time Nurse. Explore whether Nurse retention may be improved by allowing flexibility in their schedules to provide both community and office-based services, rather than the current arrangement of primarily having one Nurse assigned to each of those functions.
H9	Substance Abuse Specialist on Team	1 – 5 5	The team has two SAS positions: an SAS and a Lead SAS. The Lead SAS is a Licensed Master Social Worker (LMSW) and has been with the team about five years; in a SAS role since 2014, then moving to the lead position in July 2017. That same month, the second SAS joined the team, and based on his resume, has over ten years experience providing substance use treatment. Additionally, the CCs and SASs receive weekly supervision in Integrated Dual Disorders Treatment (IDDT) and substance use treatment related interventions.	
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has one Vocational Specialist (VS), classified as an ES. The ES has held the position since 2012, and reports trainings through the RBHA in large off-site meetings, or at the clinic. The RS position was vacant the day before the review due to the promotion of the RS to the role of CC on the team, but the staff had filled the position of RS since May 2016.	• The agency should recruit and hire a second VS with training and experience in vocational services related to assisting people identified with an SMI prepare for and attain competitive employment. VSs should be prepared to cross train other staff on the team on how to assist members in obtaining competitive employment.
H11	Program Size	1 – 5 4	The ACT team consists of nine full-time equivalent staff who provide direct services. Team vacancies include: RS, PSS, and one Nurse. Since there was limited verifiable evidence of services rendered by the float staff in ten member records reviewed, his reported time available to the team was not	• Recruit and hire qualified staff who are oriented and prepared to provide ACT services.

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			factored for this item.	
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *The ACT Eligibility Screening Tool* and *ACT Team Eligibility Criteria* developed by the RBHA to screen potential members. Staff confirmed that the team controls admissions with no organizational pressures to admit. Per report, when the team is not at census (i.e., 100 members), they first recruit from within PIR, attributed to reimbursement rates that incentivize providers to keep members in the network, but staff reported that other providers as well as hospital staff also refer.	
O2	Intake Rate	1 – 5 5	The peak admission rate in the last six months was three in May and September 2017, and admissions for the other months of April through September 2017 ranged from one to two intakes per month. Staff reported they were allowed to admit two members per week per the RBHA *Assertive Community Treatment (ACT) Operational Manual.* However, the section related to intakes in that document notes the rates for established teams should not exceed six per month.	• Ensure all staff are aware admissions to the team should not exceed six per month, rather than two per week, which would result in exceeding the maximum of six per month allowed for full fidelity on intake rate.
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team is responsible for psychiatric services, substance abuse treatment, and most employment and rehabilitative services. Though staff on the team appear equipped to provide substance use treatment, it does not appear counseling/psychotherapy is available. Some staff reported that service is referred out to other providers. Additionally, more than 10% of members are in housing where there are staff or external supports that supplement ACT team services. These settings range from residential	• The team should be capable of directly providing individual supportive counseling psychotherapy (with the necessary clinical supervision and oversight) for members; avoid over reliance on outside providers. • Work with members who reside in staffed residences to determine if other options are available where members can be supported fully by ACT staff.

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			treatment facilities to congregate housing settings that may offer medication monitoring, meal preparation, and/or notifying the ACT team when a member presents with a concerning behavior.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for members. The staff rotates coverage duties with the team's on-call phone weekly, and the CC serves as backup. Based on ten member records reviewed, there was evidence of services provided to members on evenings and weekends.	
O5	Responsibility for Hospital Admissions	1 – 5 3	The ACT team reported involvement in six of the last ten hospital admissions. Staff reported that they attempt to triage members with the Nurse and Psychiatrist to support the member on an outpatient basis prior to recommending hospitalization. However, members occasionally decide to not notify the team and certain members have a tendency to self-admit. One staff attributed this to the members' desires to have a place to stay for a short period or seek a meal. Staff reported that once they are aware that a member is at the hospital, outreach is immediate, but in some cases they are not notified by inpatient providers in a timely fashion.	• The team should discuss with members and identified informal supports the pros and cons of involving the team in issues that may lead to hospitalization; attempt to resolve barriers to the team not being involved. Increasing member engagement through more frequent and intense individualized provision of community-based services may provide ACT staff with additional opportunities to assess and provide interventions to reduce psychiatric hospitalizations and to build collaborative relationships with member's informal supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff reported the team follows the RBHA *Assertive Community Treatment (ACT) Operational Manual* as a guide to support members who experience a psychiatric admission and discharge, which they report includes five days of face-to-face contact, and meeting with the team Psychiatrist within 72 hours of discharge. The ACT team reported involvement in nine of the last ten hospital discharges. In the one instance a member was discharged without ACT team being present or notified, staff speculated the member was likely	• Educate hospital staff, members, and natural supports on the role and availability of ACT staff to facilitate hospital discharges. • On a case by case basis, determine how the team can assist natural supports, but still allow for the team to play a role in facilitating the discharge. For example, if family want to pick a member up at discharge, staff may be able to meet them at the hospital to plan for the visit to the Psychiatrist, to obtain medications, and to

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			provided with a cab ride to her residence. One staff reported that if family want to pick a member up it is discouraged, with the preference that the ACT team transport the member to ensure they have medications, meet with the Psychiatrist and are safe.	subsequently support the member's transition into the community without disallowing the involvement of the natural support.
O7	Time-unlimited Services	1 – 5 4	Over the prior year six members graduated from the team, and in the upcoming year the team expects to graduate five to six members total, with three members currently pending. If a member was not utilizing ACT services, staff reported that they were directed to consider graduation. Staff reported they are expected to graduate six members a year, and that expectation was outlined in the RBHA *Assertive Community Treatment (ACT) Operational Manual*. However, upon review, that document references that members are served on a time unlimited basis and fewer than 5% are expected to graduate annually. The team utilizes the *ACT Exit Criteria Screening Tool* developed by the RBHA.	• The team should work toward maintaining an annual graduation rate of fewer than five percent of the total caseload with a goal of ensuring all staff understands the value of increased connections and support for the members through time.
S1	Community-based Services	1 – 5 2	Staff estimates ranged from 60-70% of their time spent in the community, which was higher than the results of ten records reviewed, which found a median of 27% of all face-to-face contacts with members occurring in the community. This included three members with no community-based contact at all. In addition to substance use treatment groups which are an element of the fidelity measures, multiple members were engaged to attend clinic-based groups facilitated by ACT or other clinic staff. However, the ILS reported, and documentation confirms, that he assists groups of members with shopping in the community, as well as provides individualized ILS support.	• Other than substance use treatment groups, the team should evaluate the benefit of current clinic-based groups. For members who prefer group activities, determine if those can be fully transitioned to occur in the community with team support or in a setting that best meets the member's preference. Optimally, ACT services are delivered in the community where staff can directly assess needs, monitor progress, model behaviors and assist members to use resources in a natural, non-clinical setting.

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S2	No Drop-out Policy	1 – 5 5	Based on staff report, no members closed due to any of the following reasons: refusing or terminating services, moving from the geographic area without referral, or due to the team determining the member could not be served. Some members moved to other ACT teams or providers (8), services such as ALTCS (3), or were incarcerated for an extended period (1). Staff reported that members may be transitioned off the team to Navigators if the team is unsuccessful at making contact after a period of disengagement, but to date, no one has transitioned off the team to that status.	
S3	Assertive Engagement Mechanisms	1 – 5 2	It was reported that staff utilize a 12 week checklist to track outreach to members who are not in contact with the team. However, based on records reviewed, some members experienced gaps in contact for multiple weeks over the course of a month. For example, there was phone contact initiated by one member, but the team did not have community contact with the member when they were in the hospital. However, one staff documented an attempted visit two days after a different staff documented the member transitioned to another setting. For another member there was only one outreach, a call to a family member, in one month.	• If the team follows the RBHA *Assertive Community Treatment (ACT) Operational Manual* as a guide regarding outreach, consider modifying the team's checklist to align with this document. For example, the manual prompts for the completion of at least four weekly outreach attempts for eight weeks, with at least two of those outreach attempts in the community.
S4	Intensity of Services	1 – 5 4	The median intensity of service per member was just over 91 minutes a week, based on review of ten member records. Four members averaged more than 100 minutes of service time per week over a month period. However, for two of those members, clinic-based group participation (e.g., arts and crafts) accounted for notable portions of the service time. For example, for one member, clinic-based groups accounted for nearly 39% of	• Increase direct service time to members to at least two hours per week, on average. Direct service contacts by ACT staff should occur primarily in the community and be focused on individual needs. Staff should facilitate any skills training, groups, or therapy session in more natural settings. • Review with staff to ensure they are

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			documented service time. For another member with zero community-based contacts, group accounted for just under 67% of service time. Staff documented service durations varied dramatically for certain services. For example, some staff met with members for medication observation and home visits then documented five minutes or less of contact, while others documented over 30 minutes.	accurately and consistently documenting services rendered.
S5	Frequency of Contact	1 – 5 3	The median weekly face-to-face contact for ten members was 2.5 based on review of ten member records. Four of the records had less than six contacts documented in the past month, but some highly served members received 19 or more.	• Increase the frequency of contact with members by ACT staff to average four or more per week. Certain members may receive more or less contact week-to-week than the average, based on individual needs, status goals, etc. which should be identified in the individual service plan.
S6	Work with Support System	1 – 5 2	The ACT team has infrequent contact with informal supports, which one staff termed as natural supports. During the morning meeting observed, contacts with informal supports were infrequently referenced. Staff recounted contacts with members from the prior week, but contacts with informal supports over the same period were referenced for about 8% of members. During interviews, one staff estimated that half of all members have informal supports, with the team contact goal of averaging about two times a month, but likely occurring about monthly. Staff appraisal in this area was slightly above the actual contact with informal supports documented in ten records reviewed, which yielded an average of approximately 0.6 interactions during a month reviewed.	• The team should encourage members to identify natural and informal supports and discuss with them the benefits of involvement in their treatment. • Proactively engage informal supports on average four times monthly as partners in support of recovery goals. Some programs have developed family psychoeducation activities as one aspect of their outreach efforts. Seek training and guidance, whether at the agency or through system partners, to learn strategies related to engaging informal supports. • Document contacts with informal supports when they occur.
S7	Individualized Substance Abuse	1 – 5	The team provides individualized Substance Abuse treatment to a limited subset of 42 members	• Monitor member participation in individualized substance use treatment

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	Treatment	4	diagnosed with a co-occurring disorder. One staff reported 19 members received individual treatment, primarily meeting with the Lead SAS for individual treatment. However, another staff reported that four members meet with an SAS for weekly individualized treatment sessions usually lasting 30 – 45 minutes in duration. The remaining members of the 42 are reportedly engaged by the SASs about weekly. However, weekly engagement by the SASs was not found consistently in applicable records reviewed. When located, the duration of those contacts varied from under ten minutes to more than 20 minutes, but seemed to focus primarily on prompting the member to attend group.	through the SASs. Review documentation of individualized treatment during supervision with SASs to ensure services align with the members' stages of change and stage of treatment, and to gauge duration and frequency. • Ensure all members identified with a substance use disorder are being engaged weekly for substance use treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team currently offers three weekly co-occurring disorder treatment groups facilitated by SAS staff, two of which are held at the clinic and one that is held at a congregate living setting where a subset of ACT Varsity members reside. Staff reported the groups focus more toward earlier stages of treatment, due in part to many members assessed to be in earlier stages of recovery. Staff confirmed it can be challenging to modify the group for members in later stages, and that all topics discussed may not be relevant. Those members are engaged in individual treatment. Based on available data, the reviewers were able to confirm that about 19% of the members identified with a co-occurring diagnosis participated in group treatment. One staff estimated about ten members attended a co-occurring group over the course of a recent month, and another staff estimated about 19	• Consider revising the approach of how groups are implemented. Rather than open to all members regardless of stage of treatment, consider modifying one group for members in earlier stages, and at least one specific group for members in later stages of recovery. • The ACT team should engage members diagnosed with a co-occurring disorder to participate in treatment groups. At least 50% of dually-diagnosed members should attend at least one treatment group monthly. • Consider obtaining sign-in sheets for groups so that participation can be tracked. This may aid in targeted interventions with those who may not be attending groups who are likely to benefit based on their identified stage of treatment (e.g., persuasion).

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			attended but added that number may have reflected four to six weeks of data. It was difficult to verify staff reports; group sign in sheets were requested but were provided for only two groups over a recent four-week period. In ten member records reviewed, three members attended a co-occurring treatment group once over a month period reviewed. Member calendars were provided summarizing services provided over the month of September, and four of those members participated in at least one co-occurring group.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	It appears the team employs a mixed model approach to treating co-occurring disorders. The team draws from Dartmouth Psychiatric Research Center (PRC) Hazelden resources including: *Integrated Dual Disorders Treatment (IDDT)*, *IDDT Recovery Life Skills Program*, and *Illness Management and Recovery (IMR)*. Harm reduction is reportedly the focus over abstinence, but staff had difficulty citing recent examples of harm reduction interventions. One staff referenced encouraging members to obtain safe needles, but had difficulty identifying a resource for that action. Another staff gave an example of assisting a member explore options to address boredom in order to reduce cigarette use, but was not able to cite another recent harm reduction intervention. Based on documents provided, the SASs received substance use treatment related trainings and supervision. The SAS interviewed appeared to be informed of the stages of change model and corresponding stage-wise treatment, but it was not clear if the entire team practices from that approach. Additionally, it was not evident that the team uniformly assesses member stage of change	• Train all staff in a stage-wise approach to treatment in relation to stages of change. Members benefit from consistent use of best practice approaches. As staff receive training, they will have a shared understanding of effective treatment interventions. • Ensure all staff are working from a harm reduction approach. The team would benefit from further review of documenting harm reduction tactics and approaches in treatment plans and notes. • Review and formalize the team approach to assessing, documenting, and communicating stage of change and stage of treatment information so staff can plan and implement interventions accordingly. For example, the act of inviting members to group is not in itself an intervention. Reviewing member status over a recent month and then discussing the stage of change and treatment interventions may be a useful exercise during group supervision.

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			or effectively communicates that information across the team so interventions can be aligned to stage of treatment. Some staff documented multiple stages of change related to the same member during the same interaction. For example, one staff identified a member to be in the contemplation preparation stage of change. For the same member, nine days later, another staff identified the member to be in the precontemplation stage of change, but with no apparent change in the member's status between the two interactions. In treatment plans reviewed there was limited evidence that stage-wise treatment interventions were incorporated to support member goals. Some documentation reflected a mixed perspective, referencing sobriety or for a member to minimize or discontinue substance use, without it being clear if those were the stated preferences of the members. One member with no identified substance use diagnosis was offered IDDT. Also, during an interview and in one record reviewed, staff referenced members being *clean and sober.*	• As an aspect of ongoing clinical oversight, consider including review of recovery language, for example noting that a person is *maintaining recovery*, or is *drug free* in place of *being clean and sober*.
S10	Role of Consumers on Treatment Team	1 – 5 1	At the time of review there was no one identified as employed with the team who was a person with a lived experience. The Peer Support Specialist (PSS) position has remained vacant since July 26, 2017.	• Hire individuals with lived experience to fill vacancies (e.g., PSS) and consider broadening the depth of team understanding by hiring other persons to provide a perspective of lived experience.
Total Score:		**3.43**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	1
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	4
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	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	4
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	2
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	1
Total Score	**3.43**	
Highest Possible Score	**5**	