ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: December 16, 2015

To: Juliette Briggs, Clinical Coordinator

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ADHS Fidelity Reviewers

Method

On November 16-17, 2015, Jeni Serrano and TJ Eggsware completed a review of the Saguaro Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

The Saguaro clinic is located at 3227 East Bell Road in Phoenix, Arizona. This team began providing services in November, 2014, and at the time of review, the ACT team served eighty-five members. With a total of eleven staff, this team has a full time Psychiatrist and two full time Nurses, with only one vacancy for a Substance Abuse Specialist.

The individuals served through the agency are referred to as "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 team meeting on November 16, 2015
- Individual interview with team leader/Clinical Coordinator (CC)
- Member interviews of five members who receive ACT services
- Individual interviews with Substance Abuse Specialist (SAS), Case Manager (CM), and Employment Specialist (ES)
- Charts were reviewed for ten members using the agency's electronic medical records system
- Review of the *ACT Admission Screening Tool* developed by the Regional Behavioral Health Authority (RBHA), the agency *Engagement/Outreach Closure Checklist*, the agency *Saguaro ACT Team Pre-Referral Form*, and the agency *Assessing ACT Appropriateness Tool*.

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 team currently has two full-time nurses that function as full members of the team, including conducting home visits, community medication observation rotation with other team staff, participation in treatment planning, administering medications, attending daily morning meeting, and offering education to the members and the staff.
- The team Nurses provide a high level of services to members of the team with medical conditions. Nurses attend medical appointments and treatments with the member and provide medical coordination and follow through.
- The team has small caseloads, with a member to staff ratio of nine to one; this allows for this newer team to establish rapport and engagement with members.
- The team meets four days a week for the daily morning meeting. The Psychiatrist and Nurses attend meetings, all members on the team are discussed, even if only briefly.

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

- The agency needs to evaluate administrative duties and activities of the CC in order to increase community direct service percentage. It is recommended that she increase to spend at least 50% of the time providing direct services.
- The team should increase the intensity and frequency of services to members. Services should be delivered primarily in the community and not the office setting; the team should identify what services are currently delivered in the clinic setting that can be provided to members in the community. Some staff appears to have a narrow definition of "fidelity"; many staff define fidelity only as the frequency of contact with members, but not other fidelity items. Staff may benefit from further education and guidance from the agency, RBHA, as well as coordination with other ACT teams that align their practices more closely with the full evidence based practice and fidelity measures.
- The team needs to increase their efforts to involve members' identified support system. It is recommended that the team support and encourage members to identify their informal supports (i.e., people not paid to support members, such as family, landlord, neighbor, friend) and then assist them in acquiring the knowledge, resources and skills needed to support members.
- Continue to engage members with substance use challenges to participate in individual and group treatment. The team should implement a recognized integrated dual diagnosis treatment to standardize the team approach when working with members with substance use challenges.
- The vacant Substance Abuse Specialist (SAS) position should be filled by experienced staff so the team will be better positioned to provide individual SA treatment based in an integrated treatment model. The SAS needs to provide regular, direct, substance abuse treatment to members with a co-occurring diagnosis. Ensure ongoing supervision and training is provided.

- Overall, the staff views ACT services as rather time limited. ACT services are designed to be available for as long as the member wants them. Creating arbitrary time limits or transitioning without the member being fully confident in their ability to remain successful can cause regression. The team should prioritize retention until the member expresses full confidence in their ability to succeed in a lower level of care.
- The team needs to comply with explicit admissions criteria and only accept members who meet the criteria. In addition, the team should commit to taking in new members at a low rate to maintain a stable service environment.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The member to staff ratio for this team is 9:1. This team has 85 members and 10 staff. This count excludes the Psychiatrist and the administrative support staff. At the time of review this team was short one staff, the second Substance Abuse Specialist.	
H2	Team Approach	1 – 5 (3)	The team reported that the entire team shares responsibility for each member on the team; however, through review of the records, data showed that only 60% of members have been seen by more than one team member in a two week period. Members interviewed stated that they usually see their assigned primary case manager; however, if they are at the clinic they see other staff on the team.	• The agency leadership should ensure members are being seen by each staff member on the team, rather than only their assigned primary case manager. This is the point of members being on an ACT team: a multidisciplinary approach by 12 staff. • The team needs to plan encounters focused on needs of members and allow each staff person to contribute based on their area of expertise, as appropriate.
H3	Program Meeting	1 – 5 (5)	The team meets four days a week for the daily morning meeting and the expectation is that all staff on the team is to attend. The Psychiatrist and Nurses attend meetings, occasionally missing a day or coming in late -- if providing direct service. All members on the team are discussed, even if only briefly. During the meeting the Nurse shared information related to coordination with medical providers, including direct contact with those providers when the Nurse attended appointments, and updated the team regarding member medical treatment. However, much of the morning meeting focused on discussions of medication services (e.g., monitoring, adherence, adjustments).	• Support specialty positions on the team, including direct service updates, and cross train other staff on appropriate interventions.

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H4	Practicing ACT Leader	1 – 5 (1)	CC reports that about 10% of her time is spent providing direct services to members. The CC stated that she has no restrictions on what she can do, is able to transport members, conduct home visits, provide medication observations, etc. Even so, the CC states she does not get out in the field to provide direct services due to her staff being out in the field, the need for office coverage, administrative duties, paperwork, and the team always dealing with crisis. Encounter reports indicate less than 1% of the CC's time is spent providing direct member services.	• CC should continue to provide community-based services; increase direct services (i.e., face-to-face contact with members) to 50% in order to remain connected with the members served by the team and model appropriate clinical interventions. • Review CC administrative tasks to determine if any of those can be transitioned to other staff at the clinic or agency to allow the CC more time to provide direct member services. • The agency should facilitate communication between the CC and other ACT CCs who provide a higher intensity of direct services to determine if there are strategies or techniques the CC can implement.
H5	Continuity of Staffing	1 – 5 (4)	Team was established in November 2014; within one year, four staff left the team resulting in a 33% turnover rate.	• If not in place, the agency should consider using staff satisfaction surveys to determine what is working to retain staff as well as staff exit interviews/surveys to determine what contributes to staff turnover.
H6	Staff Capacity	1 – 5 (3)	The team operated at 73% staff capacity; there were 39 total vacancies over the twelve-month review timeframe. The team is a new ACT team and was not fully staffed at time of program inception. The team currently has only one vacancy of SAS positon.	• See recommendation for H5.
H7	Psychiatrist on Team	1 – 5 (4)	The ACT team is assigned one, full-time Psychiatrist for 85 ACT members. Although the Psychiatrist works a flex schedule, staff reports that he is accessible and attends morning meetings as schedule permits. CC and staff report	• Consider having the Psychiatrist provide more service in the community for those members who need engagement and who miss scheduled clinic appointments.

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			that the Psychiatrist does provide coverage for other teams approximately 10% of his work-week. Besides offering coverage as needed, the Psychiatrist has no other administrative duties outside of the team. Per staff interviews and records reviewed, the Psychiatrist does not provide services in the community unless it is at the hospitals. Members interviewed all reported that they meet with the Psychiatrist in the office only, with some noting the contacts were brief (e.g., ten minutes) which was consistent with records reviewed; some visits were 14 minutes or less.	
H8	Nurse on Team	1 – 5 (4)	The ACT team currently has two full-time Nurses; one nurse is the lead Nurse at the clinic, and the CC estimated that she spends approximately 20% of her time with duties in that capacity. Although both Nurses work a flex schedule, staff reports that the Nurses are accessible, attend morning meetings, provide injectable medication, health monitoring, PCP coordination, and physical and behavioral health support. Staff interviewed and documentation reviewed confirmed that the Nurses provide services in the community; this included medication support, attending appointments with members, and outreach to meet with members who missed appointments.	• The agency should work to reduce nursing responsibilities outside of the ACT team. • Continue efforts to support both Nurses as they increase their community-based services to ACT members, such as community-based medication observation or related activities. Some members go to the clinic for medi-set services through the team Nurses, but also receive medication observation in the community.
H9	Substance Abuse Specialist on Team	1 – 5 (3)	The team currently has one identified, full time Substance Abuse Specialist (SAS) who has been with the team since May 30, 2015. The SAS reported that he does not have any formal education, licensure or state certifications, but he does have a Peer Support Specialist training/certification. He also has lived experience with a co-occurring condition and four years of	• The team should have at least two staff members with at least one year of training or clinical experience in substance abuse treatment, per 100 members. • Continue efforts to recruit experienced staff for the SAS position. Ensure staff receives ongoing, effective training,

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			work experience working with rehab, men in the community, veterans that are afflicted with substance abuse issues and volunteer work with twelve step programs. The SAS reported he receives direction and seeks monthly supervision from the Clinical Director, who is licensed and has experience in substance use treatment. The agency is recruiting to fill the second vacant SAS position.	guidance and supervision with a focus on appropriate assessment and intervention strategies to work with members to address co-occurring challenges. ACT team members often have comorbidity issues; a substance abuse specialist is critically important.
H10	Vocational Specialist on Team	1 – 5 (4)	The team currently has two identified Vocational Specialists: an Employment Specialist (ES) and a Rehabilitation Specialist (RS). During interview, the ES reported eleven years of past work experience in employment related positions including work adjustment training, workshops, and sub-minimum wage jobs, working close with vocational staff and VR services as well as past work experience as a CC of an ACT team. The CC reported that the RS on the team has less than one year's vocational experience and many years of case management experience, and that both the ES and RS attended the last quarterly training/meeting provided by the RBHA. However, the extent of the RS experience specific to vocational supports was not identified. Due to the team being new as of November 2014, there is not enough data to support if vocational staff is offering vocational services that enable members to find and keep jobs in integrated work settings.	• Ensure both vocational support staff receive supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings.
H11	Program Size	1 – 5 (5)	The team currently has 11 staff including the Psychiatrist (excluding administrative support staff). The team has one open SAS position.	

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O1	Explicit Admission Criteria	1 – 5 (4)	The CC provided the admission criteria, used to screen potential members for appropriateness for ACT services. Though the ACT population is clearly defined, the team reports that due to being a new team, they have had pressure to accept members even if they didn't completely meet the ACT criteria in order to get their census up. Staff report there is a misconception within the behavioral health system that this team is classified as a Medical ACT (MACT) team, and as a result, referred members tend to have co-occurring medical issues.	• Continue to carefully screen members for ACT appropriateness prior to admission, with the team making the final determination. If members are not appropriate for ACT services, work with referral sources to identify and facilitate admission to a more appropriate level of care whenever possible. Continue to educate referral sources that the team is not classified as a MACT team.
O2	Intake Rate	1 – 5 (1)	The team's monthly intake rate in the last six months ranged from three (May 2015 and September 2015) to 16 members (October 2015) The team reported that they were required by both the RHBA and the SWN to accept a high rate of members to increase their census. The team also experienced a flux in members over the review period due to members refusing services (eight members), and deceased members (five members).	• Admit members at a low rate to maintain a stable service environment; admissions should be no greater than six per month. • The team was established in November of 2014. Once the team has operated for an extended period of time, and the ACT team meets full capacity, the monthly intake rate should stabilize.
O3	Full Responsibility for Treatment Services	1 – 5 (2)	The team provides case management and psychiatric services. The CC and staff interviewed reported that the team refers externally for some substance abuse and employment/rehabilitation services, housing and all counseling/psychotherapy. Staff reports about 9-15% of members are in settings with staff and services (e.g., 24 hour residential settings, group homes, care facilities). It was reported there are barriers to the team referring members to residential treatment due to the duplication of services through the ACT team. To address this issue, one staff proposed to	• Provide members with staff names and contact information; consider including descriptions of positions and duties in order to familiarize members to the ACT team staff composition. • The agency should consider tracking referrals from the ACT team to external providers. The team should provide the majority of services directly to members (i.e., 90% or more). It is not clear how much time referrals and necessary coordination with outside providers takes away from staff providing a high intensity of services

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			transition members to Supportive treatment with the recommendation they be referred to residential following the transition. Additionally, in some of the ten records reviewed, home visits were inconsistently documented, and often focused on medication adherence or prompts to complete home cleaning. Some members stated that staff do not come to their home on a regular basis. When staff performs a home visit, duration ranges are usually under fifteen minutes. One member interviewed stated that her case manager has not conducted a home visit in months, another member stated that case managers come to the home about every fourteen days, and don't stay long, maybe a few minutes. In some areas, it appears the team is still working to engage and assess members. The SAS offers a weekly group, but reports low attendance. The SAS offers motivational interviewing and engagement, but the team also refers out to external treatment facilities, programs or detoxification facilities. The ES is currently working with an estimated 15 members on the team to engage and assess work readiness, with no vocational support services to date; members have obtained their own jobs or are not ready to work.	directly through the team; one staff estimated it takes about 45 minutes to complete referral paperwork for some programs. • Some teams elect to review service delivery by specialty staff position during the team morning meeting; this approach may help to bolster the specialty staff positions and interventions on the team.
O4	Responsibility for Crisis Services	1 – 5 (4)	The team reported that they offer 24-hour, seven days a week crisis coverage directly. The team rotates an on-call phone; the CC provides emergency service backup all the time. Members interviewed report that "Staff will not come out to the home after hours. You call crisis and once you call crisis then the team has to come to the home." Not all members interviewed were	• The team should ensure members are aware of the 24-hour crisis service through the team, including who to call, and back up contacts.

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			aware of the crisis services or the on-call phone number.	
O5	Responsibility for Hospital Admissions	1 – 5 (4)	Based on the data provided, the ACT team was involved in seven out of ten hospital admissions; the team reported that there are some members who have self-admitted and either family or landlord assisted. The team was notified after admission.	• The team should continue to build rapport and educate members on the benefits of ACT involvement in the decision to hospitalize. • Provide staff contact, and on-call contact information to members and their informal supports. Discuss with informal supports how the team can support members to potentially divert a hospital admission, or to assist with the admission process when clinically indicated. • The agency and RBHA should explore opportunities to improve communication with local hospitals on the inpatient status and condition of members.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (4)	Per data and CC interview, the team is involved in most hospital discharges. However, there was evidence that the team was not involved in one of the ten most recent discharges reviewed; the member left against medical advice and the team was not involved in discharge. All ACT staff interviewed stated that discharge planning begins once the member becomes hospitalized. The team maintains regular contact with hospital Social Workers for discharge planning. Following discharge, the team maintains five day follow-up with members, and coordinates an appointment with the Psychiatrist within 72 hours of discharge.	• Continue to participate in hospital discharge planning meetings as often as possible.
O7	Time-unlimited Services	1 – 5 (4)	During the morning meeting reviewers observed, there were six members identified for graduation from services. Staff stated that members were ready to transition to a supportive team, noting	• ACT services are designed to be available for as long as the member wants them. Creating arbitrary time limits or transitioning without the member being

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			they had not utilized ACT services or had a crisis situation. Per morning meeting observation and CC interview, it is estimated that 5-17% of members will be discharged within a year.	fully confident in their ability to remain successful can contribute to regression. The team should prioritize retention until the member expresses full confidence in their ability to succeed in a lower level of care.
S1	Community-based Services	1 – 5 (3)	Per ten member records randomly selected for review, the ratio of services delivered in the community verses those delivered in the office ranged from 0-86% with a median of 42% face-to-face contacts in the community. Staff report they rotate community visits by region, one week focusing on their caseload and the next week focusing on another caseload.	• The agency and CC need to review staff duties and activities to assure that staff is supported to spend at least 80% of total service time in the community. Work with ACT team staff to brainstorm ideas to increase community-based services. Supportive housing services, assisting with employment goals, peer support services, individual SA treatment, and other skill development activities should occur in the community rather than the clinic whenever possible. • The team Psychiatrist should consider increasing community-based services.
S2	No Drop-out Policy	1 – 5 (4)	The team reports eight members have refused ACT services and one member left without a referral. Team reports they continue to engage and retain 80-94% of members over a twelve-month period.	• The team and agency should review the reasons members leave the team or refuse services; the team may benefit from additional training or support (e.g., motivational interviewing or other structured intervention techniques). • The team, agency and RBHA should evaluate why the ACT team is referring members to 24-hour residential treatment. Consider whether services through a fully functioning ACT team (e.g., substance abuse treatment, housing support services) may more appropriately meet member needs over residential treatment services.
S3	Assertive	1 – 5	The team reported that there is an	• The team needs to make sure that outreach

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	Engagement Mechanisms	(4)	*Engagement/Outreach Closure Checklist* to follow when members need outreach; the form notes at least six weeks of outreach is needed before closure. Staff reports the team performs outreach for six weeks. The team uses engagement and outreach strategies such as medication observations, home visits, hospital visits, coordination with guardians, payee services, and street outreach in areas members are known to frequent to keep members engaged in treatment. There were also examples of the team working to assess the need, and to arrange, for member advocates through the Office of Human Rights. During the morning meeting observation, it did not appear that outreach activity occurred as outlined in the desktop procedure nor was there evidence in files reviewed. Staff reported they "accidently found a member" when in the community, but it was not clear if intentional and planned outreach consistently occurs when members are not in contact with the team.	attempts are documented in members' charts as outlined in the agency desktop procedure. • Consider revising the outreach checklist procedures to include more frequent outreach efforts and/or an extended outreach timeframe.
S4	Intensity of Services	1 – 5 (3)	The median intensity of service per member was 50.88 minutes a week based on review of ten member records. Service intensity ranged from an average of seven to 188.5 minutes per week; six members received 52 minutes or less on average per week.	• Increase the intensity of services to members, optimally averaging two hours a week or more of face-to-face contact for each member. Explore what actions the team can take resulting in higher service intensity per member.
S5	Frequency of Contact	1 – 5 (2)	The median weekly face-to-face contact for ten members was 1.50 based on record review. Staff estimated a higher frequency of contact with some members, especially those who receive medication observation services. Members interviewed stated they do not see their case managers regularly;	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member. Ensure outreach occurs for members who are not in contact with the team, as well as those

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			they mostly see them at the clinic in the lobby or when walking the halls to activities or appointments. Staff report that at the direction of the RBHA, weekly calendars will be developed to plan out staff contact with members.	who are incarcerated. • The team should consult with other ACT teams who maintain higher frequency of contacts with members to discuss effective strategies that can be implemented on this team.
S6	Work with Support System	1 – 5 (2)	The data provided implies the ACT team provides occasional interaction with members' support systems. The ten member records reviewed indicated that the team averaged .90 contacts per month with the member's support systems with contact often initiated by the informal supports. The CC reports approximately 50 members on the team have supports, with the team averaging about monthly contact with those supports. Some members interviewed reported that the team is not in contact with their supports, and if there was contact it was often initiated by family members.	• Focus on documenting team contacts with member support system(s) in a consistent fashion, to ensure this measure is being accurately captured. • Continue to encourage and educate members on the benefits of the involvement of informal supports. • Consider developing a family psychoeducational group where families have the opportunity to expand their social networks, support each other, and learn techniques from each other on how to support members to address psychiatric and medical concerns.
S7	Individualized Substance Abuse Treatment	1 – 5 (2)	The team does not currently provide regular, direct, substance abuse treatment to members with a co-occurring diagnosis. The staff indicated that members can discuss concerns with the SAS; however, these interactions are generally informal and unscheduled. The SAS reported he tries to meet with six to ten targeted members for at least 30 minutes weekly; depending on other demands during any given week, sometimes these interactions do not occur, but he cited at least one example of a member with whom he has built rapport and engaged in scheduled weekly contacts. Some members who need individualized treatment are referred to external treatment	• The agency needs to fill the vacant SAS position as soon as possible. The team should have at least two full time staff with one year of training or clinical experience in substance abuse treatment. • The team should directly provide substance abuse treatment, including individual treatment, without relying on referrals to outside providers that are not integrated into the team. • The agency should provide the support and any additional training to ensure that the SAS provides this service within the ACT team.

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			programs in the provider community (e.g., Terros).	
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	The ACT team offers one hour-long substance use treatment group weekly. Based on staff report, there are forty-nine members identified with co-occurring diagnosis, and only two or three members with substance abuse challenges attend group treatment through the ACT team regularly, with at most five members attending at least once a month. The SAS and CC are aware that the group attendance is low and plan to continue to work on engaging and encouraging members to attend group to increase attendance. The SAS facilitator reports he does not utilize the provided RHBA curriculum; the group is structured as more of a peer based processing group focusing on relapse, triggers, and stressors. The SAS reports the agency is working to develop a standard curriculum.	• Continue to explore engagement strategies that will increase member attendance. (i.e. open house, motivational interviewing, etc.) • If not already, the RBHA and agency should ensure that appropriate training and education is provided to ensure the ACT teams are specifically following an established, stage-wise curriculum, such as integrated dual diagnosis treatment (IDDT).
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	Although some staff on the team use motivational interviewing and are aware of a stage-wise approach to treatment (including the concept of harm reduction), it is not clear if the team follows a consistent treatment model in day to day interactions. The SAS used stages of change language; however, during morning meeting observation, other staff used language of dirty/clean when describing drug screenings. The team offers a SA treatment group weekly, but as noted above, the group does not follow a specific treatment model, and no standard curriculum is utilized. The team refers members to community support groups (e.g., AA or NA) as supplements to what is offered through the SAS. The team refers members to detoxification when medically indicated but also in some cases when	• Establish methods for tracking member progress through the stages associated with a dual diagnosis treatment model. As members improve (or decline), SAS staff can communicate the effective interventions associated with that particular “stage of change” to other team staff with the intention of improving treatment planning outcomes and increasing member participation in substance abuse treatment. Standardize the team approach to treatment utilizing a proven model. • Ensure the team language aligns with a recovery approach (e.g., not using “clean” and “dirty”). • The team should directly provide SA

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			medical detoxification may not be required. The team is new and SAS and staff are working on building rapport with co-occurring members and moving at the member's pace. The SAS interviewed was familiar with the 12-step model, sees the value of self-help groups for some members, has some experience with a co-occurring treatment model, and appears to be open to learning more about appropriate interventions (e.g., supporting a harm reduction approach). Treatment plans generally incorporate stage of change language as measures of member progress (for substance use issues as well as other areas being addressed).	treatment to the majority of members who receive that type of support.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	Members are employed on the team full-time, with full professional status, and the ACT team has an identified Peer Support Specialist. ACT staff includes those with a history of substance use, and with lived experience of mental illness. Per member report, staff share their personal experiences with members, are supportive, and relatable, though not all are aware there is a Peer Support Specialist on the team.	• Provide members with staff names and contact information; consider providing descriptions of staff responsibilities by position in order to familiarize members to the ACT team staff composition.
Total Score:		**3.32**		

ACT FIDELITY SCALE SCORE SHEET

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

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	3
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.32**	
Highest Possible Score	**5**	