ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 5, 2015

To: Larry Villano, Senior Vice President

From: Georgia Harris, MAEd
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ADHS Fidelity Reviewers

Method

On October 6 -7, 2015 Georgia Harris and Karen Voyer-Caravona completed a review of the Terros West McDowell 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 West McDowell ACT team and the West McDowell clinic is operated by Terros, a comprehensive healthcare organization founded in 1969 to respond to the behavioral health and treatment needs of people struggling with substance abuse and addiction. Today, Terros is known for its expertise in mental illness and co-occurring disorders and has expanded their scope of services to include the integration of behavioral health and primary medical care. Terros recently acquired several clinics and ACT teams formerly operated by the Choices Network. The fiscal year (FY) 2014-2015 West McDowell ACT fidelity review was conducted when the team operated under the Choices Network. While transitions can be stressful and potentially disruptive for both staff and clients, the ACT team has benefitted from the continued leadership of the team's Clinical Coordinator, who was identified as a significant strength in the FY 2014/2015 review. Additionally, ACT staff reported benefitting from the increased availability of training and educational opportunities provided by Terros.

The individuals served through the agency are referred to as *clients* and *members*; 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;
- Individual interview with the ACT Clinical Coordinator (i.e. Team Leader);
- Group interview with two Substance Abuse Specialists (SAS);
- Group interview with the Housing Specialist (HS) and the Independent Living Specialist (ILS);
- Group interview with four members receiving services;
- Review of ten member clinical records using the agency's electronic medical records system;
- Review of agency documents such as member roster, ACT team morning meeting roster, member contact tracking log, and ACT admission criteria.

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:

- Substance Abuse Specialist on the team: The ACT team has two Substance Abuse Specialists (SAS) with extensive training and experience in both substance abuse and behavioral health. The SASs offer two substance abuse specific groups per week, including one in Spanish, that are exclusive to ACT team members.
- Vocational Specialist on the team: The ACT team provides members with an Employment Specialist and a Rehabilitation Specialist with significant professional experience in helping people with disabilities find employment.
- Nurse on team: The ACT team benefits from the services of two nurses who are assigned full-time to the team. One nurse is available to members at the clinic, while the other nurse primarily offers services to members in the community, conducting home and hospital visits, and coordinating care with primary care providers.

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

- Community-based services: Evidence was found that ACT staff tended to over-estimate the amount of community based contacts they provide members. The team should strive for 80% of contacts in the community. ACT is most effective when

service delivery takes place outside the structured clinical setting, where members live their lives, where their challenges actually occur, and where new behaviors can be modeled by staff, supported, and mastered.

- Intensity and frequency of services: Since the amount of face-to-face service time and frequency of contacts is positively associated with improved outcomes, it is recommended that the Clinical coordinator (CC) conduct a regular review of member records and provide mentoring to staff to increase frequency and intensity of contacts that are person-centered and reflect recovery goals. Continued empowerment of staff to function in their areas of specialization rather than referring to brokered services may help the team improve fidelity in this area.
- Individualized substance abuse treatment: Terros should consider options for allowing the ACT team, particularly the two experienced Substance Abuse Specialists, to provide individualized substance abuse treatment within the team, including opportunities for any necessary training and credentialing, or clinical oversight.
- Dual disorders model/Integrated dual diagnosis treatment: The ACT team would benefit from and Terros should provide more experiential training and education in the co-occurring treatment model in working with members with substance use disorders. Given that nearly half of current West McDowell ACT members are dually diagnosed, it is critical that all staff demonstrate knowledge and competencies in stage-wise interventions harm reduction, motivational interviewing and other behavioral techniques.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, the ACT team consists of 12 staff members (excluding the team Psychiatrist) providing services to a roster of 99 members. The staff to member ratio is 1:8.25.	
H2	Team Approach	1 – 5 5	A review of ten member records found evidence that 90% of ACT members see two or more staff within a two week period. Staff cover their own caseload but also see each other's members "when we are in the neighborhood." The team uses a face-to-face home visit tracking sheet to ensure members are seen and record how often each member is seen.	
H3	Program Meeting	1 – 5 5	The ACT team meets Monday through Friday for a minimum of one hour and reviews each member. The meeting is organized such that members who are currently hospitalized are reviewed first, followed by blue dot calls. Members are then reviewed according to needs status/areas of specialization such as substance abuse treatment, housing and employment and then each staff member's case roster. In the meeting observed by the reviewers, the CC demonstrated an active, directive leadership style, appeared knowledgeable about all members, and focused on responding to member needs and well-being.	
H4	Practicing ACT Leader	1 – 5 3	The CC provides 24 hour back up for emergencies, accompanies the team Psychiatrist on weekly half-day home visits to members, attends hospital discharge planning meetings, and was praised by ACT staff interviewed as being actively engaged in supporting the team in providing direct member	• On high fidelity ACT teams, CCs provide direct member services at least 50% of the time, serving as a mentor and modeling appropriate interventions to the staff they supervise. The program should continue to explore and seek solutions to barriers to

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			services. The CC said that she spends 25% - 50% of her time providing direct member services, part of which are weekly home visits conducted in conjunction with the team Psychiatrist. This estimate could not be verified, however, by either the record review or the CC's activity log, which showed that for the period August 31 – September 29, 2015, the CC had a total of 13.26 hours (8.3%) of direct member contact.	the CC providing direct services to member. A time study is recommended to determine nonessential activities that could be eliminated, reduced or assigned to other staff, such as the PA. • Make sure the CC is documenting her time to accurately reflect member contacts.
H5	Continuity of Staffing	1 – 5 3	In the two years previous to the fidelity review period, 24 individuals held 13 staff positions on the ACT team, for a turnover rate of 42.3%. Since the completion of the 2014-15 fidelity review five positions have turned over. The CC reported that she prioritizes relevant experience and professional fit in hiring for specialty positions.	• To improve performance in this area, ACT staff turnover should be no more than 20% in two years. If not already in place, the provider should consider using staff exit interviews to determine factors contributing to high staff turnover. Staff satisfaction surveys should also be administered to gather feedback on factors that would (or currently) contribute to staff retention. • The CC and Terros should continue to give priority consideration to job candidates with education and professional experience in behavioral health and areas of specialization.
H6	Staff Capacity	1 – 5 4	The ACT team is currently fully staffed. For the period of review the team has operated at 94.2% of capacity.	• See recommendations for Item H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT team Psychiatrist is the clinic's Medical Director. The Psychiatrist is assigned full-time to ACT members, although he is also helping to cover a supportive team while the clinic seeks an additional Psychiatrist. The Psychiatrist works four, ten-hour days, Tuesday – Friday. Monday is his "flex day", when he is assigned eight hours to see supportive members. Since all the clinic's	• The clinic and the team should carefully monitor the activities of the Psychiatrist in his capacity as clinic Medical Director to ensure that those responsibilities do not distract from his responsibilities to the ACT team members.

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			Psychiatrists have emergency visits built into their schedules, one of the other Psychiatrists will cover his supportive caseload if he needs to see an ACT member on a Monday. The Psychiatrist other non-ACT duties are also scheduled on Mondays. ACT staff interviewed described the Psychiatrist as recovery oriented, focused on "what we can do to get members working . . . he believes in the least restrictive environment, and is open to reducing medications." The Psychiatrist spends at least one half day each week conducting home visits with the CC. Staff finds him to be very accessible, carrying a laptop so that he can staff on-calls and issues that arise on weekends.	
H8	Nurse on Team	1 – 5 5	ACT members are serviced by two full-time nurses. One nurse sees members primarily in the clinic, Monday through Friday. The other nurse sees members mainly in the community, such as home and hospital visits, Tuesday through Saturday, and is focused on coordinating care with primary care providers (PCP). Both nurses attend the morning team meeting and are viewed by staff as very accessible.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team includes two SASs, who have a combined 20 years of specific training and clinical experience in substance abuse treatment, across a variety of settings, including outpatient clinics, residential, and family service agencies. Previous to joining the ACT team, the SASs both provided individual and group treatment. One SAS has extensive experience in substance abuse prevention and family reunification, as well as relapse prevention. The other SAS has provided substance abuse treatment to individuals and their families who are also involved in the corrections system.	

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H10	Vocational Specialist on Team	1 – 5 5	The ACT team has two vocational staff, each with at least two years training and experience in assisting behavioral health recipients in finding employment. The ES previously worked at Goodwill assisting individuals in finding work, while the Rehabilitation Specialist (RS) was previously employed in the same position on a supportive team and prior to that worked as a counselor for Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR).	
H11	Program Size	1 – 5 5	The ACT team has a staff of 13, including the team Psychiatrist, to provide services to 99 members.	
O1	Explicit Admission Criteria	1 – 5 4	While the ACT team has explicit written admission criteria in the form of a checklist, the CC assesses potential members independently. The CC actively recruits new members within the clinic, and when meeting with other supportive team providers and hospitals. The team occasionally accepts administrative transfers that the team otherwise would not deem appropriate. For example, the team has had to accept members who transferred from other ACT teams due to threats of and/or violence against other members or staff, while in another case the team has been pressured to accept individuals being discharged from Arizona State Hospital. Documentation also indicated that some members who were court ordered to treatment refused further services after the order was removed. The team occasionally accepts members whose diagnosis does not meet the ACT admission criteria when the CC and the team assess that the individual needs the intensive level of support. For	• The ACT CC, Psychiatrist and staff should continue efforts to carefully screen potential members for their appropriateness for ACT services, with particular attention paid to issues suggesting coercion. The potential member must be agreeable to services, and those services must offer a clear benefit that would not be available to the individual at a lower level of care. • ACT services are designed for people with the most significant serious mental illnesses and those dually diagnosed with substance use disorders, not merely those users of behavioral health services who providers find difficult to serve. The ACT team should be cautious about accepting members who do not meet the explicit criteria and for whom ACT is not anticipated to be a long-term approach.

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			example, one new member with a mood disorder currently requires in-home psychiatric and medical care that is beyond the capacity of a supportive team. The CC anticipates that with ACT support, combined with cognitive behavior therapy, the member will be able to step-down to a lower level of care in 12 months.	
O2	Intake Rate	1 – 5 5	The team's average monthly intake rate for the six months prior to the review was 2.6 members. July and August had the highest admission rates of three members per month.	
O3	Full Responsibility for Treatment Services	1 – 5 3	Along with case management services, the ACT team provides all psychiatric and most housing services. Approximately three members reside in staffed housing situations. Two members live in supervisory care homes and receive case management services limited to meals, medication observations, and hygiene prompts, while another member lives in community living placement. The ACT team otherwise provides those members with transportation assistance and socialization along with more in-depth case management services. Until recently, the team received "mixed messages" about who was responsible for assisting members in finding employment. The team was instructed to refer all members who were interested in work to VR. VR subsequently would refer member to job development services provided by outside agencies such as DKA and Marc Community Resources. The team has since clarified this question with VR, so that job development will occur within the ACT team. The current ES previously worked with one of the largest employment agencies in the Phoenix Metro	• The agency and the Regional Behavioral Health Authority (RBHA) should continue efforts to provide education, training and support of specialty staff needs to bolster their ability to be the primary service delivery agents for members. Referrals to outside providers should only occur when it is beyond the capacity of ACT specialty staff to fulfill, such as EMDR or sex offender relapse prevention. • The ES and the RS should receive targeted on-going training on the principles of supported employment. Technical assistance on how SE principles are applied on an ACT team may be beneficial to reduce reliance of brokered employment services. • Improve coordination with VR to emphasize a focus on competitive employment, which has been found to have superior outcomes over traditional approaches such as WAT and other pre-employment activities.

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			area. She uses her expertise to provide employment assistance to members such as help with resume writing, job search/job development activities (such as job fairs and arranging meetings with potential employers) and mock interviews. The RS provides VR coordination and attends a monthly staffing with the VR Counselor for a full update on member status. VR may refer members to pre-employment, work adjustment training (WAT) programs, or supported employment at separate agencies. The exact percentage of members using WAT services through VR is unknown. While the two SAS staff provided two substance abuse treatment groups per week that are specific to the ACT team, they do not provide formal, structured and individualized substance abuse counseling. Individualized substance abuse treatment services are referred to a co-located licensed Valle Del Sol clinician, who attends a morning team meeting once a week. Members who are legally mandated for specific treatment concerns such as psychotherapy, counseling to manage sexual preoccupation with children, or require eye movement desensitization and reprocessing (EMDR) to treat past trauma are referred to the co-located Valle del Sol clinician.	
O4	Responsibility for Crisis Services	1 – 5 5	On the ACT team, staff carry the on-call phone on a rotating basis for a week. A second staff person is assigned back-up for the on-call staff, and the CC provides standby services for the back-up staff. Each staff member is on-call once a month, and the CC always is available for staffings and will meet the on-call staff and member on-site if	

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			necessary. On holidays, the CC always assigns three staff (along with the CC) to be on-call. The mobile crisis unit is only used if it is unsafe to transport a member.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The ACT team strives to avoid psychiatric hospitalizations in keeping with the philosophy of "least restrictive environment". When ACT staff learn that members are experiencing a crisis or are requesting to be hospitalized, they arrange for the member to meet with the Psychiatrist. Sometimes hospitalizations can be resolved with a change in medication. The Psychiatrist makes the determination about whether or not to hospitalize. Some members admitted themselves to the psychiatric hospital, and some members were transferred to psychiatric facilities while hospitalized for medical issues. Documentation provided to the reviewers indicated that that the ACT team was involved in 70% of the last ten psychiatric admissions.	• The RBHA should review system challenges to promptly informing ACT teams when members are admitted to inpatient facilities. • Continue to educate and train ACT members (and their support networks when allowed with an ROI) on the benefits of engagement with the ACT team, as well as the purpose of ACT services when experiencing psychiatric decline.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per interview and documentation provided to the reviewers, the ACT team was involved in 100% of the last ten hospital discharges. The ACT team begins discharge planning immediately upon learning members have been admitted to the hospital; contact with the hospital social workers occurs within 72 hours of admission. While in the hospital, members are seen at least every 72 hours. Staffings are weekly until discharge, and if the stay extends beyond one week, the team arranges for doc-to-doc.	
O7	Time-unlimited Services	1 – 5 4	During the period of review, six members (6.1%) graduated from the ACT team, stepping down to a supportive team. Members may step down if they are not utilizing services, are able to function	• In the absence of stable, ongoing therapeutic relationships, members often regress when terminated from short-term programs. The ACT team should exercise

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			independently over an extended period of time, and if they want less intensive services. The transition to a lower level of care occurs in a 30/60/90 day process. If during this period the member states a need to remain on the ACT in order to avoid crisis or maintain functioning, the stepdown can be cancelled. In the next 12 months, the team leader expects that approximately 10 members (10%) will also stepdown to a lower level of care.	caution when considering graduations or step-downs to lower levels of care that might be inadequate to members in crisis or insufficient social supports. See recommendations for Item O1, Explicit Admission Criteria.
S1	Community-based Services	1 – 5 3	ACT staff report that about 75% of services are provided in the community. A review of 10 randomly selected member records found that 46% of contacts took place in the community, with a range of 25% on the low end and 71.43% on the high end. Most community-based contacts appeared to occur in the context of safety/wellness checks and medication observations and delivery.	• The ACT staff and Terros should identify and find alternatives to policies and practices that may tie staff to the clinic, thereby limiting their time for delivering in vivo services. • Avoid implementing services that require members to go to the clinic as opposed to the community. ACT is most effective when service delivery occurs in nonclinical, real life settings where new coping skills and effective behaviors can be practiced and mastered.
S2	No Drop-out Policy	1 – 5 5	In the 12 months previous to the review, three members (3%) left the team because they refused ACT services. Two refused services but agreed to be transferred to a supportive team. One refused to continue services after court ordered treatment was lifted. Two other members left the team due to incarceration or detention pending trial for a serious criminal offense. It should be noted that two ACT members were transferred to other ACT teams due to assaultive and/or aggressive behaviors directed toward ACT staff.	

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S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team has an eight week contact strategy for locating members who disengage from services, but report that it sometimes is extended to ten weeks. The team makes use of numerous assertive engagement mechanisms to ensure members remain in contact with the team. The team uses letters and phone calls. ACT staff will contact probation officers, shelters, the morgue, emergency rooms, and visit peer run agencies or other know hangouts to locate members. Said one staff member, "We go anywhere they go . . . CASS, Circle K." Another ACT staff said the team also reaches out to ABC Housing often to locate members who have disengaged from services. In some cases, staff coordinate with Representative Payees to forward checks to the clinic so that members will have to come there to pick them up.	• The team should reconsider engagement strategies that require the member to come to the clinic. With respect to having members pick up checks at the clinic, it is recommended that ACT staff consider going to the payee when the member is scheduled to collect the check or that staff take the check to the member somewhere in the community.
S4	Intensity of Services	1 – 5 2	A review of ten member records found evidence that members receive an average of 43.88 minutes of contacts per week. Though many staff have well-documented encounters with members, during the record review it was noted that a portion of the staff contacts with members were brief, casual encounters that lacked therapeutic substance.	• The RBHA, Terros and the CC should explore barriers that inhibit service intensity. Time studies, staff surveys and an examination of non-direct services may be useful in identifying inefficiencies and if all activities are essential to a functioning ACT team. • The RBHA, Terros and the team should consider options for increasing direct service time, particularly that which is spent in the community delivering services through specialty positions. Services provided in the community where challenges and learning new behaviors are most likely to occur and reducing reliance on brokered services may lead to higher fidelity in this area.
S5	Frequency of	1 – 5	A review of ten member records found evidence	

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	Contact	3	that members had face-to-face contact with ACT staff 2.25 times per week. Staff interviewed said frequency or contact (as well as service intensity) is challenged by administrative factors such as documentation requirements, travel time/geographical distance between destinations, and unreliable computer hardware when in the community.	• As with Item S4, Intensity of Services, greater frequency of contact is associated with improved member outcomes, with the goal of members having contact with ACT staff an average of 4 times per week. The CC should review member charts to ensure that staff contacts with members are person-centered, recovery focused, and meet specific needs, goals, and objectives. • The ACT team may wish to explore implementing a rotating weekly zone-based coverage, which some ACT teams have found helpful in increasing frequency of contact.
S6	Work with Support System	1 – 5 3	The ACT team attempts to obtain a signed release of information form for each member. Per staff interview, an average of 40% of members have an informal support network. Of those, ACT staff have contact with them approximately one time per month. One member interviewed said that ACT staff has regular contact with his sister. Due to the format of the morning meeting observed by the reviewers, it was difficult to track the number of staff contacts with member supports, however, approximately the reviewers counted approximately five contacts in the preceding 24 hours. A review of ten member records found a monthly average of 1.9 team contacts with informal supports per member.	• To meet fidelity in this area, the ACT team should have four or more contacts per month for each member with a support system. The ACT team should continue efforts to obtain ROIs. If not already doing so, ACT staff should periodically discuss with members the benefits of allowing staff to have contact with important individuals within the member's support network.
S7	Individualized Substance Abuse Treatment	1 – 5 3	Despite two experienced SASs, the ACT team does not provide formal, individualized substance abuse treatment; the CC and SASs reported that the team lacks licensed staff for this service. However, evidence was found in member records that members are regularly engaged in discussions	• In order to increase fidelity in this area, Terros should consider strategies to provide individualized substance abuse treatment by the ACT team. If licensing or certification is required to perform the service, Terros should identify what

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			about their substance use during their contacts with staff. The SASs describe meeting irregularly on an individual basis with two to three members "who do not do well in group". The SASs said that some members are reluctant to express feelings in group settings, and others wish to avoid exposing their lack of reading and writing skills to the group. The content of the one-on-one meetings mirrors that of the substance abuse group sessions, and are used to gauge the members' stage of change, assess needs, and engage in substance abuse treatment. Approximately, five to six members receive formal, individualized substance abuse treatment from the co-located Valle del Sol provider.	requirements are necessary to support the SASs and other ACT staff in obtaining the necessary credentials. • As an experienced substance abuse treatment provider with credentialed clinicians, Terros may be well positioned to take advantage of opportunities to provide clinical oversight and supervision necessary to offer individualized substance abuse treatment. Technical assistance in this area and consultation with stakeholders at the RBHA and AZDHS/DBHS level is recommended.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The SASs provide two substance abuse treatment groups that are exclusive to the ACT team. The groups meet on Tuesday and Friday. The Tuesday group is facilitated in Spanish for members who are more comfortable speaking in Spanish, and uses a psychoeducational approach to introduce concepts such as *stages of change* and relapse as part of the change cycle. The Friday group is oriented around 12-step principles; once a month the group attends a 12-step group somewhere in the community so that members are exposed to a wider range of testimonial about coping skills. Both are focused on "prevention rather than judgment". Forty-seven members of the 99 member ACT team have been diagnosed with a substance abuse disorder. Five to ten members attend each group, and five to six (calculated as 5.5 /47 = 12%) members regularly attend the groups. Staff said members who attend regularly are usually in "action" stage of change.	• The ACT team should develop person-centered strategies to increase member motivation to participate in substance abuse treatment so that 50% of those members identified with a co-occurring disorder COD are attending at least one substance abuse group a month. • See Item S9 regarding increasing all ACT staff in their knowledge and skill in implementing the COD model.

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S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The ACT team uses a mixed model to address substance abuse, integrating 12-step principles with the co-occurring disorders model. Staff interviewed said that while abstinence is the desired goal, it is not realistic for many members so harm reduction strategies are employed to encourage reducing use and using less lethal substances. Detox is employed only for the most severe cases when the member is symptomatic and/or under the influence of substances and requires medical support. Although critical to the implementation of the COD model, staff interviewed said that most of the team have limited knowledge of the stage-wise approach to substance abuse treatment and would benefit from more education and training. Said one staff member, "We need everyone to have knowledge of the stage-wise approach, because all need to engage with the members who have substance abuse issues. They need live training rather than computer-based."	• Because the co-occurring disorders model is a collaborative and multidisciplinary approach, Terros should take steps to ensure that all ACT staff are well grounded in the COD/Integrated Dual Diagnosis Treatment model. Staff would benefit from opportunities for live training or on-site supervision or mentoring in stage-wise interventions and motivational interviewing techniques.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team includes a full-time Peer Support Specialist with full professional status. Staff report that the PSS has been an asset to the team, bringing with her a greater level of understanding of the experience of people living with an SMI. "The language in our meetings used to be horrible. Now that we have people with lived experience it has drastically changed . . . her disclosures have changed the team positively." In addition to the PSS, the CC reported that she and two other ACT staff are people with lived experience.	
Total Score:		**4.07**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	5
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	5
3. Full Responsibility for Treatment Services	1-5	3
4. Responsibility for Crisis Services	1-5	5

5. Responsibility for Hospital Admissions	1-5	4
6. Responsibility for Hospital Discharge Planning	1-5	5
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	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	3
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	5
Total Score	**4.07**	
Highest Possible Score	**5**	