ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Tomás León, President & CEO
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ADHS Fidelity Reviewers

Method

On December 3 – 4, 2014, Georgia Harris and Karen Voyer-Caravona (Fidelity Reviewers) completed a review of the People of Color Network's (POCN) Centro Esperanza 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.

According to information published on the agency's social media page, the People of Color Network is an "integrated community healthcare network" providing "behavior and physical health services through collaborative care approaches, culturally and linguistically responsive services to over 6000 adults, youth, children and their families" throughout Maricopa County. Within the Adult Services Program, the Centro Esperanza ACT team serves 98 adults living with a serious mental illness (SMI), 43 of whom are also diagnosed with a Co-Occurring Disorder (COD). The ACT Team is housed at the Centro Esperanza clinic, located at 310 South Extension in Mesa, Arizona. The clinic is accessible by public transportation and designated bicycle route. The South Extension site also houses supportive treatment services, and *Valle del Sol* service providers are co-located there to offer individual counseling and substance abuse treatment groups. Fully staffed, the ACT team consists of 12 full-time staff, excluding administrative support: a team Psychiatrist, a Clinical Coordinator/Team Leader, a Registered Nurse, an Employment Specialist, a Housing Specialist, an Independent Living Specialist, a Peer Support Specialist (PSS), a Transportation Specialist, a Rehabilitation Specialist, two Substance Abuse Specialists (SAS), and an ACT Team Specialist. At the time of the review, the two SAS positions and the ACT Team Specialist positions were vacant.

The individuals served through the agency are referred to as members and sometimes "clients", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used. ACT team staff are referred generically as "staff", "case managers", or by specialty area such as Housing Specialist or Substance Abuse Specialist.

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

- Observation of a daily ACT team meeting;
- Individual interview with Team Leader;
- Individual interviews with immediate past Substance Abuse Specialist, Housing Specialist, and Peer Support Specialist;
- Group interview with six members receiving services;
- Individual interview with one member receiving services; and
  Review of 10 member electronic records.

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:

- ACT Psychiatrist: The ACT team benefits from a full-time Psychiatrist who attends and actively participates in four treatment team meetings weekly. Both ACT team staff and members speak highly of his clinical knowledge and skills, as well as his ability to listen and engage members. The Psychiatrist also conducts a weekly round of home visits with a rotating schedule of Case Managers, usually seeing four to five members each week.
- Program Meeting: The ACT team meets five mornings a week to report on the status and needs of each member. Detailed issues are discussed such as primary AXIS I diagnosis, dates of recent visits or missed appointments with the Psychiatrist or Nurse, date of last home visit/jail visit, notes and action plans and any medical issues.
- Intake Rate: With a current roster of 97 members, the ACT team's intake rate averages one member per month, with a total of six intakes completed in the six months previous to the fidelity review.
- Time Unlimited Services: The ACT team provides time-unlimited services, retains a high-percentage of members, and makes good use of assertive engagement strategies, including: street outreach, legal mechanisms, and contacting hospitals,

shelters, jail and the morgue to maintain connection to or locate members.

- Peer Support Specialist: The ACT team PSS serves as a fully functioning member of the team, with professional status and responsibilities equal to the other staff. The PSS appears to have a high level of commitment to the team and contributes actively to the daily meeting member review, offering insights on member activities and presentation.

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

- Practicing ACT Leader: Although the Team Leader estimates that 50% of her time is devoted to direct member services, there was no documentation that reflected face-to-face member contact. In high fidelity ACT teams, the Team Leader dedicates at least 50% of his or her time to direct face-to-face member contact, both in the office and in the community attending home visits, co-facilitating treatment groups, mentoring newer ACT staff members, and advocating for member aftercare at discharge planning. The Team Leader should make sure that any member contact is tracked and documented. Also, the agency should review other Team Leader activities that may be interfering with direct member service, and if these could be moved to other staff.
- Staffing: High staff turnover and associated understaffing are areas in need of attention. In the last two years, the Centro Esperanza ACT team has experienced a significant turnover rate. Staff turnover can disrupt team cohesion and the potential for strong, therapeutic relationships between staff and members. In order to maintain consistent interdisciplinary services for members, ACT teams should strive to maintain sufficient staff capacity – at 95% or more. It is incumbent upon the PNO to identify factors contributing to the high level of staff turnover on the ACT team and to make efforts supporting staff retention; this may include working with the RBHA to provide meaningful training and education that will improve staff morale and confidence, while developing expertise in in their respective areas of specialization.
- Full Responsibility of Treatment Services: The evidence-based practice of ACT is based on the team assuming responsibility for all treatment services, which generally includes psychiatric services, counseling/psychotherapy, housing support, individualized substance abuse treatment, and employment and rehabilitation services. In addition to case management, the ACT team provides psychiatric services and housing support. Employment/vocational services and substance abuse treatment services are largely brokered to outside providers. The agency should explore education and training opportunities to provide more services in-house.
- Service Delivery: Per a review of member records, just 39% of services are delivered in the community, and members receive a moderate intensity of face-to-face contact with ACT team staff weekly. High fidelity ACT programs are successful in delivering at least 80% of services in the community, with members receiving at least four staff contacts a week for a total of two hours. High staff turnover may challenge the team's ability to meet these fidelity requirements. This should be a focus for the team when staff reaches closer to full capacity.
- Substance Abuse Treatment and Co-Occurring Disorders Treatment Model: The Centro Esperanza ACT team currently has no Substance Abuse Specialists. It is recommended that the ACT team actively recruits two staff with at least one year training

and supervised clinical experience in substance abuse treatment for its 100 members. Preferably, the Substance Abuse Specialists would have the credentialing to provide that individual and group substance abuse treatment using the Co-Occurring Disorders treatment model, which is critical due to the significant amount of ACT members with a dual diagnosis. Currently, those services are brokered to either the co-located provider, Valle del Sol, or to the Terros Ladders program, although it is unclear what treatment model is utilized. The ACT team would benefit from in-depth and ongoing training in the Co-Occurring Treatment Model and how to administer it within the agency.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	4	With three vacant positions at the time of the review, the ACT team functioned with nine staff to 98 members, for a ratio of one staff member for every 10.88 members. Staff described carrying individual caseloads ranging from between 15 – 17 members due to high staff turnover.	• The ACT team should maintain a level of staffing that provides a member to staff ratio of 10:1.
H2	Team Approach	1 – 5 3	Per a random selection of 10 member records, 60% of members saw more than one staff over the last full two week period documented prior to the review. Staff carry distinct caseloads and report that they must see each member on their caseload at least once every week. Additionally, the team also provides zone coverage wherein case managers conduct home visits with members outside their caseloads. Zones are assigned and rotate weekly, so that case managers get to know and contribute their specialty area to meeting the needs of all ACT members. Zone assignments also appear to be used to help member contact expectations.	• It is recommended that efforts be made at the clinic and PNO level to provide services to members with primary consideration for need and staff specialty versus general caseload assignment in order to ensure a variety of team members are involved in each member's care. Resolving challenges to staff capacity (H6) may play a role. • To the greatest extent possible, the specialty staff should be able to perform their specialist role as a primary function on the team. Preferably, staff would not have individual caseloads, but the team as a unit would be responsible for service provision supporting all members.
H3	Program Meeting	1 – 5 5	The ACT team meets five days a week, Monday – Friday, between 9 – 10:30 a.m. All members are discussed at the daily meeting and all case managers have ample opportunities to share impressions, new information or suggestions for intervention.	
H4	Practicing ACT Leader	1 – 5 2	The Team Leader estimates that 50% of her time is spent in direct, face-to-face contact with members. However, no records reviewed documented any member contact with the Team	• It is recommended that a time study is utilized to identify the amount of time the average CC on ACT teams spends on completing administrative functions,

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			Leader. Although requested, the reviewers were not provided with a copy of the Team Leader's productivity report.	attending meetings, or engaging in other duties without direct contact with members. If each activity is essential, it should be reviewed to determine if some can be streamlined or transitioned to other system, clinic or agency staff. • Review documentation procedures to ensure that the Team Leader is consistently recording all direct, face-to-face member contacts, including intakes, hospital visits, after hours emergency visits.
H5	Continuity of Staffing	1 – 5 3	In the last two years, 11 people have worked in 12 positions on the ACT team, resulting in a turnover rate for that period of 45%. Three people have served in the position of Housing Specialist; four people in the position of Rehabilitation Specialist; two people in the position of ACT Team Specialist; two people have served as Team Leader; and the team is currently without two Substance Abuse Specialists. It is worth noting that the person currently in the Employment Specialist position had given her resignation and in her last week with the team at the time of the review. Increased workload due to chronic understaffing was identified by staff as a barrier to meeting agency expectations regarding member face-to-face contacts and documentation requirements. Understaffing may be a factor in employee turnover. Consistent staffing helps to foster trusting relationships between members. ACT teams in good fidelity have a two-year staff turnover rate of 20% or less.	• The clinic, PNO and RBHA should identify factors contributing to high staff turnover, possibly through exit interviews and employee surveys, and develop a plan to support staff retention. This may be an area of further ongoing network, clinic and system review. • The PNO and the RBHA should implement training and educational opportunities that not only build knowledge but expand clinical skills and expertise, support credentialing, and increase staff confidence in having a positive impact on individuals with the most significant psychiatric symptoms and quality of life challenges. This will potentially benefit team morale, as well as member outcomes and service utilization. • Consider implementing experiential hiring practices such as job shadowing for potential new ACT team staff, particularly for those job candidates new to the ACT model.

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H6	Staff Capacity	1 – 5 1	The ACT team has nine of 12 full-time positions staffed. For the last 12 months, the program has operated at 41.6% staff capacity that produces several significant challenges in providing good fidelity ACT services to members..	• See recommendations for Item H5.
H7	Psychiatrist on Team	1 – 5 5	The ACT teams benefits from a full-time, 100% dedicated psychiatrist. Staff and members hold him in high regard for his openness, ability to listen and engage members, accessibility, and clinical judgment. The psychiatrist makes weekly home visits with a rotating schedule of case managers. At the team meeting, he was actively participated in discussion about members. He provided both a leadership and educational role but also demonstrated interest in the input of other members of the team.	
H8	Nurse on Team	1 – 5 3	The team nurse is well regarded by both interviewed staff and members. At the team meeting, she gave input on members' medication, physical health needs, and attendance to scheduled appointments. The nurse conducts home visits once a week with a rotating schedule of case managers. The team has only one nurse on staff.	• The PNO and RBHA should investigate the feasibility of adding a second nurse to the ACT team in order to provide more flexibility in coverage; with one nurse being available at the clinic and one seeing members out in the community.
H9	Substance Abuse Specialist on Team	1 – 5 1	The ACT team does not have a certified or licensed substance abuse counselor, but the team refers members to either the Terros Ladders program or the co-located provider, Valle Del Sol, for individual substance abuse counseling.	• The clinic and PNO should prioritize recruiting two SAS staff with at least one year training and experience in substance abuse treatment. • The PNO and RBHA should review ongoing training and supervision solutions to ensure that staff designated with a substance abuse specialty receive monitoring, support and education in their role for the

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				population served. Training and future hiring decisions should ensure that at least one of the designated Substance Abuse Specialists meets the qualifications necessary to provide co-occurring disorders specific individual and group counseling sessions (Also see recommendations for items S7 & S8).
H10	Vocational Specialist on Team	1 – 5 4	The ACT team has both an Employment Specialist and a Rehabilitation Specialist on staff. At the time of the review, the Employment Specialist, had been in the position for 11 months but had recently resigned, while the Rehabilitation Specialist had been in the position for a month.	• It is recommended that the network and RBHA implement strategies to recruit, hire and retain candidates with the educational and/or professional qualifications to perform the duties of vocational rehabilitation. • At the clinic, network and system level, explore the factors employees cite for making a change in position that leads to staff turnover. This may be an area of further ongoing network, clinic and system review.
H11	Program Size	1 – 5 4	At the time of the review, the ACT team had nine staff and three vacant positions, including the two Substance Abuse Specialists. The score for this item should be examined in the context of Items H5 and H6.	• See recommendations for Items H5 & H6.
O1	Explicit Admission Criteria	1 – 5 3	The ACT team has written admission criteria as outlined by the RBHA, and the Team Psychiatrist and Team Leader have the final says in admission. However, the Team Leader acknowledges that the team occasionally bows to external pressure and accepts referrals that do not need the intensity of service. Per staff reports, hospitals and the Department of Corrections (DOC) may not have a	• Review each ACT referral and maintain the established admission process to ensure the appropriateness of each member to the ACT team. • The PNO and RBHA should provide education to hospitals, the DOC, and other potential referrals sources regarding ACT's admission criteria and how it differs from

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			clear understanding of scope of ACT services and the admission criteria. In some cases, staff feel the ACT is used as a housing resource by other parts of the system.	general mental health members who may be in crisis.
O2	Intake Rate	1 – 5 5	The ACT team accepted six new members in the last six months. The Team Leader reported that the team accepts 1 – 2 new members per month and tries to avoid accepting any more than three.	
O3	Full Responsibility for Treatment Services	1 – 5 3	While staff are assigned areas of specialization, they do not necessarily have significant experience in their assigned roles. For example, the Housing Specialist had no previous housing experience or training previous to her hire to the role. The staff roster over the last 24 months indicates shifting of roles and responsibilities among staff. Beyond case management, the ACT team provides primarily psychiatric services and housing support. Employment/vocational and housing services are largely brokered services. Individual counseling and psychotherapy, including substance abuse counseling and treatment groups are also referred to outside providers due to lack of staff licensed to perform those services. The team provides two out of five services beyond case management.	• The PNO and the RBHA should make efforts to provide training, supervision and credentialing opportunities that empower ACT staff to perform in their areas of specialization, so that they can carry full responsibility for treatment services rather than brokering them to outside providers. • Strategies should be developed for recruiting potential ACT staff candidates with professional qualifications and/or certification relevant to the area of specialization to be filled.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour/seven days a week crisis response coverage. After hours, coverage is provided by the on-call case manager on a rotating schedule and the team leader provides back up. Members can also call the crisis line; calls are staffed.	
O5	Responsibility for Hospital Admissions	1 – 5 3	While the ACT team strives to be involved in 100% of psychiatric hospital admissions, the team participated in 60% of the last 10 psychiatric	• It is recommended that the ACT team continue efforts to collaborate with hospitals, clinics, and area human service

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			hospitalizations. Self- admissions, transfers from the ER or other instances when family or other individuals arranged the admission without notifying the team appear to account for the inability of the ACT team to participate in the admission process.	programs that could share information about potential crisis leading to a hospital admission. • Continue efforts to obtain release of information forms (ROI) and engage members' social support networks including family, landlords and faith-based support in order to further enhance proactive engagement when members experience crisis or an increase in psychiatric symptoms.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The ACT team strives to be involved in all psychiatric hospital discharges in order to assure continuity of care and avoid re-hospitalization. On rare occasions, members are discharged without the team's knowledge or before they feel the member is ready because the inpatient program may not recognize the member's baseline functioning. The ACT team was directly involved with 80% of psychiatric hospital discharges.	• At the clinic, PNO and RBHA level, develop strategies for ensuring hospitals and detox programs make every effort to obtain release of information and that ACT teams are alerted to potential discharges and aftercare planning meetings, so that members are not released on to the street without a plan for medication management, safe and sanitary housing or other shelter, and social supports to reduce the need for hospital readmission. • Continue efforts to obtain ROIs and engage members' social support networks in order to maintain lines of communication regarding pending member discharges.
O7	Time-unlimited Services	1 – 5 5	Members can stay on the ACT team, as long as they are willing to accept or want the services. The Team Leader says that she expects to see four - five (4.6%) members graduate in the next year; they will be stepped down to supportive teams because they have proved themselves to be very self-sufficient, are able to take their medications on their own, attend appointments regularly, have	

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			a support network, and are stable in the community.	
S1	Community-based Services	1 – 5 2	While staff state they may spend 50 – 70% of their time providing community-based services, a review of 10 member records indicates only 39% of staff contacts with members occurred in the community, and many of those contacts appeared to be medication observations and home visits to monitor members' basic needs such as food, cleanliness and prompt for contact. Meeting with members in the community as opposed to clinical office locations helps staff understand and monitor how members function in settings where problems naturally occur. Staff can then assist members in identifying solutions based on their strengths, practice new skills and behaviors, and learn how to access community resources and supports.	• Beyond medication observations and home safety checks, the ACT team should strengthen efforts to engage members in nonclinical, real-world, community settings where problems typically occur, support can be provided, and responses monitored for feedback or consultation with the team. • Per recommendation H5, consider implementing a job shadowing component to the hiring process so that potential ACT hires understand and have comfort with delivering community-based services.
S2	No Drop-out Policy	1 – 5 5	Members are not arbitrarily discharged from the team due to lack of contact or participation. The team makes efforts to have the member meet face-to-face with the team psychiatrist for assessment before discharging. The team also tries to make sure that there is a plan for step-down to a supportive team or some other appropriate of level of care, so that members are not left without services should they experience a crisis after leaving ACT care.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The ACT team makes use of assertive engagement mechanisms to maintain contact with members and encourage them to remain involved in services and activities. When members cannot be located, case managers go to the members' homes or	• If not already in existence, the ACT team should develop a written eight-week contact strategy for engaging members who appear to be withdrawing, avoiding or refusing services.

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			known hangouts; make phone calls to the members, contact informal supports (when there is a ROI); contact probation or surveillance officers; and call emergency rooms, the detention center, Central Arizona Shelter Services or the morgue. Staff did not describe the use of a weekly contact strategy, nor was there evidence in the records reviewed of notification letter of intent to close.	• Ensure that letters of intent to close/notices of action are properly filed in member records. • It is recommended that staff receive in-depth and ongoing training and supervision in motivational interviewing, which has been found to be a critical component of assertive engagement.
S4	Intensity of Services	1 – 5 3	A review of records indicated that members receive an average of 56 minutes of face-to-face contact with staff per week (See Item S1). High staff turnover may play a role in the amount of time case managers have available to spend with members. High intensity service is recommended for individuals with the most serious symptoms to help them maintain and improve their functioning in the community. Contact goes beyond medication observations and checking on living conditions but includes meaningful interaction focused on member specific needs. Examples are counseling, assisting members with financial issues, and community integration such as shopping, using public transportation, and communication/social skills.	• Review documentation expectations to ensure all face-to-face contacts and time spent are properly recorded. • The RBHA and PNO should develop specific strategies (training, education, document review) in collaboration with the ACT Team Leader, to assure regular intensive ACT services are being provided to clients in their communities.
S5	Frequency of Contact	1 – 5 2	Staff report they are expected to see all members on their assigned caseloads at least once a week as well as members in the rotating zones for home visits. Per a review of member records, members receive an average of 1.38 face-to-face contacts per week with staff. High staff turnover may be a	• See recommendations for Item H6 – Staffing Capacity. • Review documentation expectations to ensure all face-to-face contacts are properly recorded.

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			factor in frequency of contacts. Higher numbers of direct service visits by multiple ACT staff better ensure active engagement of members and greater opportunities for responsive, multidisciplinary input on member status and any necessary interventions supporting stability in the community. According to the SAMSHA protocol, frequent contacts are associated with improved consumer outcomes.	
S6	Work with Support System	1 – 5 2	It was not clear how much contact staff have with members' informal support networks. One staff member said that for the estimated 40 members who have a support system, staff have almost daily contact with informal supports due to the intensity of services received. However, none of the interviewed members indicated that they had any family involvement in their services. A review of the member records showed that staff have an average of less than one contact with an informal support per week.	• Ensure that ACT staff review with members the potential benefits of engaging with informal supports. Also staff should attempt to secure an ROI allowing them to contact potential supports. • If a member has an identified support system, but declines to sign an ROI allowing the team to initiate contact, this should be documented in the member record. • Ensure that staff understand that if a support contacts the team, it would generally be appropriate for ACT staff to receive information from the support. • Ensure that staff document contacts with informal supports in the member records for accurate history of member needs, concerns, status and possible action taken.
S7	Individualized Substance Abuse Treatment	1 – 5 1	The ACT team does not currently have a Substance Abuse Specialist. Historically, individual substance abuse counseling has been referred to either the Terros Ladders program or *Valle Del Sol*, the co-located provider for the entire clinic. It is not clear what treatment model is being utilized by the	• At the PNO and RBHA level, provide training and educational options that could result in licensing and certification for individual counseling and substance abuse treatment (See recommendations for Items O3, S8 & S9).

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			provider. Currently, staff report that only one member diagnosed with a co-occurring disorder is receiving individual substance abuse counseling.	• Also at the PNO and RBHA level, consider structural changes that integrate outside providers of individual counseling services as full-fledged members of the team who are following the Co-Occurring Disorders Treatment model of substance abuse treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 1	The Valle Del Sol co-located clinician offers four substance abuse treatment groups weekly, as well as an anger management group. The groups are offered to all clinic members rather than exclusively to recipients of ACT services. It is not clear to what extent the groups utilize the Co-Occurring Disorders Treatment model, but staff indicates the curriculum deals with substance abuse issues. Staff describe group facilitation as somewhat confrontational, although attendees are not required to actively participate in discussion or group activities.	• Review team, PNO and RBHA options for hiring or training a Substance Abuse Specialist to provide substance abuse treatment groups using the Co-Occurring Disorders Treatment model. • Review the substance abuse treatment groups' curriculum to ensure a Co-Occurring Disorders Treatment model is utilized.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 2	ACT staff describe abstinence as a treatment goal but an ideal one that often must take a backseat to harm reduction strategies, which take into account each member's readiness for or stage of change. While ACT team staff appear to have a rudimentary understanding of the Co-Occurring Disorders (Dual Disorders) model and appear to be familiar with terminology and concepts, there is no evidence from either the records or interview that staff are implementing it as an evidence-based practice.	• It is critical that the Team Leader and future Substance Abuse Specialists receive in-depth and experiential training in the COD model. • All staff should receive on-going review of the principles of COD, including motivational interviewing, harm reduction and stages of change.
S10	Role of Consumers on Treatment Team	1 – 5 5	The current Peer Support Specialist has been with the team since its origination. The Team Leader expressed deep appreciation for his contributions to the team and his ability to engage effectively	

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			with members. During the team meeting, the PSS participated actively and in an assertive manner, reporting his impressions and interventions with several members. Both he and the Team Leader agree that he functions as a full member of the ACT staff with equal responsibilities and expectations.	
Total Score:		**3.21**		

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	2
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	1
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	1
10. Vocational Specialist on Team	1-5	4
11. Program Size	1-5	4
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	3
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	3
6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
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	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	1
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**90/28=3.21**	
Highest Possible Score	**5**	