ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: December 18, 2017

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AHCCCS Fidelity Reviewers

Method

On November 14-15, 2017, Annette Robertson and Georgia Harris completed a review of the Southwest Network (SWN) Mesa Heritage 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.

Southwest Network operates outpatient treatment centers serving persons diagnosed with a Serious Mental Illness (SMI). Five of those clinics offer ACT services. The Southwest Mesa Heritage clinic (formally known as *Hampton*) has been located at their current site for more than one year. Since the last review in October 2016, there has been a change in Clinical Coordinators (CC) with a gap of more than six months when the team did not have a dedicated CC to guide and mentor the team. Fortunately, the team have several staff that has been on the team for multiple years.

The individuals served through the agency are referred to as "clients" and "members", 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 14, 2017;
- Individual interview with Team Leader/Clinical Coordinator (CC);
- Individual interviews with each of the team's two Substance Abuse Specialists (SAS) and the Rehabilitation Specialist (RS);
- Group interview with ten members who receive services from the ACT team;
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of the following resources and documents: Mercy Maricopa Integrated Care (MMIC) *ACT Admission Screening Tool*; SWN *ACT Admission/Transfer/Discharge Desktop Procedure;* SWN *Lack of Engagement Desktop Procedure*; MMIC *ACT Exit Criteria Screening Tool*;

the SWN *Groups 2 Go Substance Abuse Group* manual; CC *Encounter Report* for month of October 2017*;* SASs and RS resume and training records; and the weekly schedule for SAS plans to see members with co-occurring disorders.

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 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 Team: The team has two full-time SASs on the team as of June 2017. Both have several years of experience with substance use disorders and appear motivated and committed to serving the members on the ACT Team.
- Responsibility for Crisis Services: The ACT team takes responsibility for 24-hour crisis services. The team has rotating weekly on call responsibilities among the specialists, with the CC as the backup and support. If the CC is out on leave, she will arrange backup from another CC or the ACT Coordinator. The Psychiatrist and Nurses are available by phone and if the team Psychiatrist is unavailable, an on-call Psychiatrist for the clinic will assist the team with member needs. In addition, the team has staff regularly scheduled for Saturdays and Sundays as part of their weekly set schedule.
- Responsibility for Hospital Discharges: The team has an excellent history of being involved in hospital discharges. Of the records reviewed, the team assisted with ten out of ten discharges and appears to take their role very seriously. The team coordinates with treating physicians and social workers, attends staffings either in person or by phone, and is active in discharge planning. Staff report the hospitals work hand in hand with them on discharges and if needed, will wait to discharge if a member does not have a "safe plan".
- No Dropout policy: The ACT Team has a low dropout rate. During the past year, the team had very few members leave the team, and none were due to lack of contact. One member left the state without a referral, one member transferred to another clinic due to strong delusions involving the Psychiatrist, but the team did not have any members that were unable to be located and none that refused ACT team services.

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

- Community Based Services: The team needs to significantly increase from the current rate of Community Based Services at 32% to 80% or more. Contacts that occur in the members' natural environment where they live, work, socialize etc. have been shown to be more effective than contacts that occur in office or inpatient settings. ACT team services are intended to be delivered in the member's natural environment.
- Intensity of Services: This is a core of ACT team services. Providing intense services ensures that members have support from the team in the community to address issues as soon as they arise (i.e., symptom management, medication changes, crisis management, housing

issues, food resources, money management, etc.) By increasing intensity, the team will be better able to assess and assist member needs, thereby supporting them in their recovery. The team's current measure is approximately forty minutes of service per member, per week. To reach high fidelity, the team should strive for at least two hours of direct contact with members per week.

- Informal Supports: The team is missing opportunities to build natural support networks for the members. The ACT team has an average of one contact per month with informal member supports. To support recovery and build members' strengths, the team should regularly assess members' natural support system and assist members in recognizing them as an alternative to built-in program supports. Encouraging members to allow outreach and interaction with these informal supports may enhance connections weakened over time by symptoms, behaviors, and other stressors associated with SMI and co-occurring disorders. Including those supports in successes reinforces their role as valued components of the member's recovery team.
- Co-occurring Treatment Groups: Sixty-five members are identified as having a substance use disorder by the ACT team, and of those, less than 7% were documented as attending a Co-occurring Treatment Group. Consistently offering a group for members in the earlier stages of recovery, as well as a group for those later in their recovery, is highly suggested. Attempting to meet the needs of members just beginning to recognize the impact of substance use on their lives and those who are maintaining sobriety in one group may be difficult. By offering two different groups, SASs could better meet the individual needs of members and increase attendance ratios.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	Currently, there are ten full time staff on the team, excluding the Psychiatrist and program assistant, and 94 members on the census, resulting in a 10:1 member to staff ratio. However, staff and members indicated there has been a lack of coverage due to extenuating circumstances, i.e. positions not being filled and the Peer Support Specialist (PSS) being out on medical leave. (The PSS reportedly has been on Family Medical Leave and Short Time Disability since August 2017 following an accident. The PSS did work intermittingly since the accident, but it did not appear to have been more than three months of absence at the time of the review).	• See Recommendations for H5 and H6.
H2	Team Approach	1 – 5 4	The ACT Team Leader (CC) reports the team attempts to see 100% of members by more than one staff person each week, and staff interviewed reiterated the same. Members interviewed indicated typically seeing one or more staff in a two-week period. Per a review of ten randomly selected member records, the ACT team delivered face-to-face contact with more than one staff person in a two-week period 80% of the time.	• Ensure vacant positions are not left open so long that it impedes staff's ability to consistently engage with members to meet their needs.
H3	Program Meeting	1 – 5 5	The ACT team meets four times a week, Tuesday – Friday, and the Psychiatrist attends all team meetings. The CC leads the meeting, giving direction when necessary and asking for clarification when needed. All members are reportedly reviewed at each meeting; however, at the meeting observed by the reviewers, there were two members where there was no update	• Review all team members during the daily meeting, and if needed, discuss the team's plan for contact, including informal supports.

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			provided. Interviews with staff informed that the program assistant names every member at the morning meeting for team discussion/input, and reviewers did witness this at the observed meeting.	
H4	Practicing ACT Leader	1 – 5 3	The CC reports 50% of her time is spent in direct care with members and reports it "gives context" to what members need. Encounter reports revealed only 17% of CC time is documented in direct member care. The encounter report was during a time when the CC was working a full shift, i.e. no vacation time, training or other duties.	• Increase the amount of time the CC provides direct service care to members to at least 50%. ACT leaders who have direct clinical contact are better able to model appropriate clinical interventions with staff and remain in touch with the members served by the team. • The CC and the agency should identify any administrative functions not essential to the CC's time that could be performed by the program assistant or other administrative staff to free up time for direct member services. • The agency should have adequate processes to ensure accurate tracking of direct care time with members.
H5	Continuity of Staffing	1 – 5 4	During the past two years, seven staff have left the team resulting in a turnover rate of 29%. At the time of the review, the Housing Specialist (HS) had been working with the team for one week and it was reported the Employment Specialist (ES) was hired and slated to start November 20, 2017. Several staffed expressed frustration with the lengthy process of filling vacant positions and the difficulty to vet potential candidates. One staff person interviewed stated that when the team is fully staffed, it allows them to focus more on their	• ACT teams should not have a turnover rate higher than 20% in a two-year period to ensure a therapeutic relationship between members and staff. • Ensure persons interviewing for positions on the ACT team are fully aware of the demands of the job. • Conduct exit interviews to better understand reasons why staff leave.

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			specialty, bringing more "on-the-job" satisfaction.	
H6	Staff Capacity	1 – 5 4	The team operated at a capacity rate during the past 12 months of 79.9% due to a total of 29 positions being unfilled. Several positions, including the CC and ES, were left unfilled for six or more months.	• Maintaining a consistent staff enhances team cohesion and ensures adequate coverage for members. Attempt to reach a 95% staff capacity rate to improve member services. • See recommendations for H5.
H7	Psychiatrist on Team	1 – 5 5	The Psychiatrist sees only ACT members assigned to the team. The CC takes a lead role in building a healthy boundary to ensure the Psychiatrist is not pulled away from team responsibilities by other needs at the clinic. The Psychiatrist attends four meetings weekly, sees members in the community, and is readily available by phone and email according to staff report. It was reported the Psychiatrist is open to educating staff on psychiatric symptoms, medications, and other issues as they arise. Also, the Psychiatrist will provide interventions with family and offer support. All staff interviewed stated they feel fortunate to have the assigned Psychiatrist.	
H8	Nurse on Team	1 – 5 5	The team has two full-time Nurses, who see members in the clinic and also in the community. The staff and CC all agreed the Nurses are easily accessible in person and by phone, even after hours. One Nurse is the lead for the clinic. It was reported in staff and CC interviews that her administrative responsibilities do not appear to negatively impact her ability to meet the needs of the ACT team members.	• Continue to ensure lead Nurse responsibilities have minimal impact on care and service to members.

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H9	Substance Abuse Specialist on Team	1 – 5 5	The team has 65 members identified as being diagnosed with a substance use disorder. The team has two full time SAS staff. One staff (SAS1) has extensive experience in Cognitive Behavioral Therapy, which is a benefit to the team; it was reported he assists with training on the subject. The second (SAS2) is fairly new to working with members diagnosed with a SMI, but appears committed to the members and the team, and eager to learn. Bringing a Master of Social Work degree, he has more than two years' experience in substance use treatment and a few hours of substance abuse training since working at SWN.	
H10	Vocational Specialist on Team	1 – 5 3	At the time of the review, there was only a Rehabilitation Specialist (RS) on the team. The RS has been on the team for more than eight years, the past 2.5 as the RS, and has reportedly successfully assisted approximately 18 members find employment. It was reported that the ES had been hired and would start work with this team the week following the review. The RS expressed great interest in treating the whole person and encouraging members of the team to engage in healthy physical activity, but also assists members with job search, resume building, mock interviews, and discussions on the importance of hygiene and appearance.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Ensure vocational staff have adequate training in vocational rehabilitation support as it relates to members on an ACT team and maintain evidence of those trainings. • Utilize cross training of specialties among team to ensure a true interdisciplinary model.
H11	Program Size	1 – 5 5	At the time of the review, there were 94 members on the team. The Mesa Heritage ACT Team consists of a Psychiatrist, two Nurses, a CC, two SASs, a RS, an Independent Living Skills Specialist, a PSS, and an ACT Specialist. Given the number of staff at the time of review (10) the team is of appropriate size and diversity to provide services.	

Item #	Item	Rating	Rating Rationale	Recommendations
O1	Explicit Admission Criteria	1 – 5 5	MMIC ACT Admission Criteria is utilized by the team. The ACT CC personally screens all members referred for ACT. The team meets with the new member as a group to welcome and discuss goals and needs. The CC denies being forced to accept administrative transfers or other referrals that were not appropriate. The data collection sheets provided to reviewers indicate that only seven members were admitted in the six months prior to review. During the CC interview, these numbers were confirmed.	
O2	Intake Rate	1 – 5 5	During the past six months, seven new members were admitted to the team. This rate is appropriate, with the highest number of members admitted (three) in August. Reviewers were informed of a plan to admit several new members during the month of November, but reportedly will never admit more than 6 new members in one month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The ACT team directly provides psychiatry services and medication management, counseling/therapy, employment services and substance use treatment, in addition to case management services. Though the team does provide employment services to a majority of members, there is evidence of employment services being referred outside the ACT team. Per staff interviews, several members are working with employment services providers, with at least three or more working with Marc Center, and at least a couple with Focus. Duplication of services were noted in housing with	• ACT staff should make efforts to assist members in locating safe and affordable housing by applying for resources in the community, such as scattered site housing vouchers, homeless housing resources, and researching natural supports as a resource for housing. • Keeping with the integrated team approach, employment services should be delivered to members by team staff, rather than referring members to outside services providers. • Ensure the Housing Specialist position remains filled with qualified staff.

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			multiple members living in residential or assisted living situations. Staff informed they are aware that members in 24-hour residential will need to be stepped down to a lower level of care and report they are in the process of addressing that with one member specifically.	
O4	Responsibility for Crisis Services	1 – 5 5	During interviews with staff and the ACT CC, it was reported the team is available 24 hours a day, seven days a week. Staff rotates on call responsibilities one week at a time. Additionally, two staff are scheduled on Saturdays and one on Sundays. It was reported by several staff that the Psychiatrist is available by phone and when she is not at the clinic, there is an on call Psychiatrist to assist when needed. Nurses are also available by phone including after hours. It was reported the ACT CC is the first point of reference after hours. The ACT CC reports the last crisis response where staff had to meet the member in the community after hours occurred in August 2017, noting that her team is good at "engaging to de-escalate and identify coping skills".	
O5	Responsibility for Hospital Admissions	1 – 5 4	Upon review of the ten most recent hospital admissions during the CC interview, the team was involved in all but one admission. Reviewers were informed the one admission that the team was not involved in related to a member who has been struggling with substance use issues and frequently seeks hospitalization as a means to escape from stress. The CC is aware the goal is to be involved in 95% of all psychiatric admissions.	• Psychiatric hospitalization is more appropriately used when the team is involved and impacts continuity of care in a positive manner. Increase ACT team involvement to 95% of all hospitalizations.

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O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The reviewers were given information on the ten most recent hospitalizations, and discussed this information with the CC. The ACT team has been involved in 100% of all psychiatric hospitalization discharges. It was reported that a visit will be made within 72 hours of discharge, members will be seen three times a week thereafter, staff will meet with the hospital social worker, and the discharge planner will complete coordination of care form within 72 hours. Also, the Psychiatrist will complete a *doc to doc*. Staff will attend staffings at the hospital, will coordinate to ensure members have medications, reliable transport, and will be scheduled with the Psychiatrist within 72 hours, and will complete five days of face-to-face follow up. If a member is discharged homeless, the team reports they will make every attempt to see the member at homeless shelters and encourage the member to come in to the clinic to be seen.	
O7	Time-unlimited Services	1-5 4	Data collection provided to reviewers indicates that five members (5.15%) graduated from ACT services in the prior year. It was reported that one to two members have been identified as needing to be assessed for possible decreased level of care; however, the team is expecting to graduate 6 members in the next year. The ACT CC expressed a clear understanding of members' needs when changing level of care from intensive to supportive services and valuing the importance of natural supports.	• A goal of fewer than 5% of members graduating per year is recommended. ACT members often regress when they are stepped down to lower levels of care. Therapeutic relationships are more likely when services are time unlimited.
S1	Community-based Services	1 – 5 2	Staff estimates, during individual interviews, that anywhere from 50-80% of services are being delivered in the community; this includes home, hospital, and other areas such as groups at the	• Community based interactions are more effective when occurring in a member's natural environment.

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			library, as well as hiking activities in the area. Records reviewed indicated a much lower percentage of contacts happening in the community at 32%. Actual community based services may have been still lower than the percentage suggests. For example, one record showed 91% of community contacts that were for brief medication observation. On a positive, the team consistently engaged with a member who was having difficulty leaving their home. The team very appropriately involved the partner as a member of the treatment team. There was a team approach with ACT staff as well, with the Psychiatrist, Nurse and an ACT specialist being involved in supporting the member in their care.	Opportunities to observe members when interacting with other people in the community offers better information than self-report. This gives staff the chance to assess needs, monitor progress, model appropriate interactions and engage with informal supports side by side the member. • Ensure staff has the time and technology to support timely documentation of member interactions. • It is recommended that 80% or more services delivered by the ACT team should be in the community.
S2	No Drop-out Policy	1 – 5 5	Data received by the reviewers from administration indicates there were no members that refused services, nor were there any members that were closed due to inability of the team to locate. The team did have one member leave the area without a referral; however, family did contact the team when the member arrived and had connected with services. The team did transfer one member to another ACT Team due to strong delusions regarding the Psychiatrist.	
S3	Assertive Engagement Mechanisms	1 – 5 3	During the interview with the CC, the retention of members was expressed as a priority, with a clear plan for outreach. However, the records reviewed did not show outreach efforts. Also, in the morning meeting observed by reviewers, there were several members where no staff had any input as to last contact or plans for contact. For	• Utilize morning meetings not only to identify those members out of touch, but also to clarify plan for immediate outreach. The nature of ACT teams is that services are intensive and provided through an integrated

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			one member, staff stated they will do a record review to find contacts and start outreach. The team has not discharged any members due to being unable to locate.	approach. • Persistent, caring attempts to engage members should be utilized by staff to build trusting relationships. This is a critical component to an ACT team.
S4	Intensity of Services	1 – 5 2	Staff interviewed reported staff vacancies negatively affect their ability to meet individual and team responsibilities. Additionally, they estimated a higher average of face-to-face contact with members than what was corroborated. Per records reviewed, the median amount the team spends with members per week is 40.5 minutes. Only one member came close to the expected amount of time to receive services at 119 minutes; three members had less than half an hour of documented face-to-face interactions with staff during a random two-week period review of records.	• Increase the intensity of services to members, with a goal of averaging two hours a week or more of face-to-face contact for each member. • Ensure all interactions between staff and members are entered into the record. • Regular reviewing of documented contact time may improve team's application of this item • Ensure staff have the time and technology to support timely documentation of member interactions.
S5	Frequency of Contact	1 – 5 3	Average number of member contacts with staff per week was 2.13. Interviews with staff estimated having anywhere from two to four contacts per week, in the clinic and in the community. During the observed morning meeting, staff gave updates as to their last interaction or planned interaction with members. At least two members had no comment from staff. An additional member was identified as needing outreach, and the CC stated a plan to review the record for additional contacts.	• To better assist all members with symptom management and improve their functioning in the community, increase the frequency to four or more face-to-face interactions with staff per week, preferably by more than one staff person. • Regular review of records could assist the team in ensuring members are - being seen at higher rates to improve member services. • Ensure all staff interactions with members are accurately documented in the record.

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S6	Work with Support System	1 – 5 2	Staff reports approximately 25-30% of members have given permission for staff to contact informal supports and subsequently are contacted twice a month. Staff expressed that for many members, the ACT team becomes their family. Records reviewed indicated a much lower percentage of actual outreach to informal supports at an average of one per month. Of the ten records, three members had contact with informal supports.	• The benefits of the team working with informal supports may need to be regularly explained to members, in an effort to increase the number of members allowing the team to have contact. • Involve natural supports both when positive treatment steps are made and when member may need additional support. • Ensure interactions with informal supports are documented in the record with a goal of two contacts per month.
S7	Individualized Substance Abuse Treatment	1 – 5 3	Reviewers interviewed both SASs and were impressed with the knowledge and experience of the more senior SAS and his (or her?) ability to express treatment interventions as they relate to a member's stage of change. The recently-hired SAS is new to the SMI population and shows enthusiasm and a willingness to learn. The reviewers were given a document that identified members with co-occurring disorders, the area in which they lived, and the day of the week they would be seen by their assigned SAS. The record review lacked evidence of the reported weekly 30-minute sessions with every member with a co-occurring diagnosis. It was reported that for most members, sitting for more than 30 minutes "is a struggle". Of the records reviewed, members received an average of 20.75 minutes of individual SA therapy per week.	• Increase weekly individualized substance abuse meetings with members to at least once weekly. These formal individual sessions should be a minimum of 24 minutes. • Ensure individualized sessions are identifying interventions appropriate for member's stage of change.
S8	Co-occurring Disorder Treatment	1 – 5 2	Sixty-five members have been identified as being diagnosed with a co-occurring disorder. Although	• Cross train ACT team staff to ensure interdisciplinary concept is embraced.

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	Groups		it was reported that co-occurring treatment groups were taking place weekly on Thursdays, only one sign-in sheet was received by reviewers. The group was attended by four ACT team members and one other member not identified as being on the ACT team. The SASs informed reviewers of a plan to ensure all members are seen weekly on an individual basis. The member list was divided by regions to ensure an adequate use of time, however, both SASs had six to nine members scheduled for individual community contact on the same day group was scheduled. It is not clear how long this group has been offered since only one group sign in sheet was received by reviewers; and SASs do admit their numbers in attendance have been low.	• Offer separate groups for those members in earlier stages contemplation stage and those in later stages such as action and maintenance. • Ensure that co-occurring treatment groups are offered to ACT members exclusively.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	SASs speak recovery-focused language, but the Psychiatrist appears to use traditional substance abuse model language referencing need for member to reach sobriety and abstinence. This was observed in the morning meeting, progress notes and records reviewed. The SASs were fully able to articulate co-occurring treatment approach and staff spoke in harm reduction terms in interviews: however, records reviewed show traditional substance abuse theory being documented when interacting with members. It was reported that the SAS1 presents Integrated Dual Diagnosis Treatment (IDDT) trainings on Thursdays, which are attended and supported by the Psychiatrist.	• The entire ACT team needs to embrace theories of harm reduction and a co-occurring disorders model in morning meetings, interactions with members, groups, individual sessions, documentation, and service plans. • Embrace specialty of SASs and, if needed, bring in outside resources to cross train the team on theories of Co-occurring Disorders Treatment Model. Ongoing supervision of staff, specifically on theory, will help to embed practice in daily processes when delivering services to members.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has had a full time Peer Support Specialist (PSS) since November 2016. However,	• Ensure the PSS role is filled, with the

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			that team member has been out on medical leave off and on since August 2017. Both staff and members identify the PSS's absence as a loss, describing them as being an important member of the team and offering a "nurturing" characteristic.	understanding that other staff (current or future) with lived experience who have self-disclosed can fill this gap that has been much identified by members and staff. "Role of Consumers on the Treatment Team" does not necessarily have to be a person who is a PSS; it can be a specialist in another area.
Total Score:		**3.93**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	4
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	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	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	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
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	**3.93**	
Highest Possible Score	**5**	