ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 1, 2019

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AHCCCS Fidelity Reviewers

Method

On December 17 – 18, 2018 Karen Voyer-Caravona and T.J. Eggsware completed a review of the Chicanos Por La Causa (CPLC) 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 the Central Region of Arizona.

CPLC offers a variety of health and human services to families and individuals of all ages, and other community development activities. Behavioral health services, including substance abuse treatment, are offered to children, families, individuals, and older adults. This review focuses on the ACT team at the CPLC Centro Esperanza clinic. In the year prior to the review, the clinic moved to a new location, 325 North Stapley Drive in Mesa, Arizona, providing staff and members increased space and comfort.

The individuals served through the agency are referred to as "clients" or "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:

- Interview with the team Clinical Coordinator (i.e., Team Leader);
- Observation of a daily ACT team meeting on December 17, 2018;
- Group interview with four members receiving ACT services;
- Individual interviews with a Substance Abuse Specialist (SAS), Employment Specialist (ES), and Peer Support Specialist (PSS);
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of team documents, including: Regional Behavioral Health Authority (RBHA) developed *ACT Admission Screening Tool* and *ACT EXIT Criteria Screening Tool*; *Change in Level of Care (LOC)/Navigator Panel;* resume and training records for the Rehabilitation Specialist,

Employment Specialist, and Substance Abuse Specialist; ACT Team contact numbers flier, and Clinical Coordinator encounter report for a sample month timeframe.

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:

- Small caseload: The team has a member to staff ratio of 9:1.
- Psychiatrist on the team: The ACT Psychiatrist is fully dedicated to the ACT team, with no outside responsibilities, and accessible to staff and members, including providing weekly home visits.
- Explicit admission criteria: The ACT team has explicit ACT admission criteria; the CC and other staff conduct screenings of referrals and report no outside pressure to admit members to the team.
- Responsibility for crisis services: The team provides crisis coverage to members 24 hours a day, seven days a week, and members interviewed reported staff availability.

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

- Continuity of staffing: Recruit qualified permanent staff and seek to identify and address the reasons for staff turnover to reduce attrition to no more than 20% in a two year period. The team continued to experience turnover at several key positions and rely heavily on temporary staff providing coverage to mitigate position vacancies, particularly for the Nurse position.
- Substance Abuse Specialist on the team: Hire an SAS qualified to provide substance abuse treatment services to adults identified with a co-occurring disorder; train the current SAS to function in the same capacity. Both SAS should provide ongoing cross-training and mentoring in co-occurring disorders engagement and treatment to the other specialists on the team.
- Community based services: Increase face-to-face contacts in the community directly supporting members to 80% or more. ACT services should occur in the community where challenges are more likely to occur and staff can directly assess, monitor progress, and model behaviors. ACT staff should assist members to use resources in natural, non-clinical settings.
- Individualized and group substance abuse treatment: Substance abuse treatment is not currently provided through an integrated team approach. Individual substance abuse treatment and co-occurring disorders groups should be offered and provided by the SAS and/or other qualified staff.
- Co-occurring disorders model: Provide training to all staff on an integrated approach to substance use treatment, including review of: stage-wise treatment and interventions; harm reduction tactics and documentation of those interventions; working with members to

develop treatment plans written based off the member's words that incorporate co-occurring treatment language; and, the benefits of structuring multiple co-occurring treatment groups to serve members in various stages of treatment.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, ten direct service staff (excluding the Psychiatrist) provided ACT services to 89 members for a member to staff ratio of 9:1. The ACT team uses temporary staff to cover vacancies and temporary leaves of absence, to ensure necessary coverage.	
H2	Team Approach	1 – 5 3	Per a review of ten randomly selected member records, for a two week period, 50% of members received face-to-face contact with more than one ACT staff. Two members had no face-to-face contact with any staff; one member only had very brief, unscheduled contact with staff at the clinic.	• Ensure that ACT staff are familiar and work with all members; 90% or more of members should have face-to-face contact with more than one staff in any two week period. Contacts should be purposeful, directed at aiding members in achieving recovery goals, and preferably occurring in the community.
H3	Program Meeting	1 – 5 5	Per staff report, all members are discussed in the program meeting that is held four days a week, Monday, Wednesday, Thursday and Friday. A Tuesday meeting is set aside for staffing specific members, for example, to obtain team recommendations to update assessments and services plans. Because some staff work regular weekend shifts, staff attend the team meeting on the weekdays they are scheduled to work. During the meeting observed, staff referenced recent contacts with members, and planned activities.	
H4	Practicing ACT Leader	1 – 5 2	The CC reported that, based on agency tracking for October, she provides direct services about 10% - 11% of the time. The CC reported her time spent completing paperwork and providing supervision can limit the time available to provide direct services. The self-report was higher than what was reported for a recent month timeframe. Based on a recent month timeframe, the CC spent slightly	• The CC should provide direct service to members with a goal of 50% of her overall time. Sharing in the provision of community-based services will allow for opportunities to observe, train, and mentor other staff. • The CC and the agency should identify any administrative functions not essential to

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			more than 8% providing direct services to members. Few examples of CC services were documented in ten member records reviewed. The contacts were brief in nature, usually when members were visiting the clinic for other reasons.	the CC's time that could be eliminated or performed by other administrative staff to free up time for direct member services. For example, clinical supervision of the SASs provided by other qualified staff.
H5	Continuity of Staffing	1 – 5 1	In the 24 months prior to the review, 33 staff (138%) left positions on the ACT team. Included in this number were temporary contractors covering vacant positions. Per interview, nurses were the most difficult to retain. Data provided the reviewers showed that 21 staff left the position in two years; during that period the team has never functioned with more than one nurse.	• Recruit and seek to retain qualified staff who are aware of ACT staff expectations. Continuity in staffing allows the building of therapeutic relationships between members and staff. • Examine employees' motives for resignation and attempt to identify causes for employee turnover. Optimally, turnover should be no greater than 20% over a two year period.
H6	Staff Capacity	1 – 5 4	Per data provided the reviewers, the ACT team had a total of 14 vacancies in the last 12 months for a staffing capacity rate of 90%. One RN position remained unfilled for 12 months. The other RN position was covered by a series of temporary contractors until the current Nurse was hired in mid-August.	• See recommendations for H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a full-time Psychiatrist, a locum tenens (LT) who had been with the since June 2018. The Psychiatrist works four, ten hour days, Tuesday to Saturday, is fully dedicated to the ACT team, and has no outside responsibilities. He attends morning meetings except on his day off, Monday. Staff said that only on the occasional emergency will he see supportive team members. Staff described the Psychiatrist as accessible on nights and weekends over the phone, with the CC usually acting as liaison. The Psychiatrist also conducts home visits with members once a week along with a staff member.	

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H8	Nurse on Team	1 – 5 3	The ACT team has one full-time, permanent nurse, who was hired in August 2018 to fill the position that had been covered by temporary staff for over a year. A second nurse position remains open. The Nurse conducts heath assessments, orders and reviews medications with the Psychiatrist, provides medication education to members and staff, draws labs, and helps members schedule appointments with their primary care providers. The Nurse does home visits at least once a week to deliver and reconcile medications, provides medication observation, and gives injections. The Nurse is fully dedicated to the ACT team with no outside responsibilities, although for emergency coverage needs, she will occasionally see supportive team members. Staff said that the Nurse is accessible to staff by phone and willing to see members off-schedule who have missed appointments. Staff said that an on-call nurse with the agency is available to staff after hours and on weekends.	• Fill the second Nurse positions with a permanent staff to provide consistency and coverage for both clinic and community-based services. Optimally both Nurses provide services only to ACT members.
H9	Substance Abuse Specialist on Team	1 – 5 1	The ACT team has one Substance Abuse Specialist (SAS) but he does not function in the role in any capacity. At the time of the review, the SAS appeared to primarily function as a case manager. The previous SAS, who provided individual and group substance abuse treatment services, left the position in October 2018. Although the current SAS report previous experience as an SAS on another team several years ago, he joined the team as the ACT Specialist and was reassigned the position this past March. The SAS appears to have limited previous training or education in substance abuse treatment, currently receives no specific training in the subject, and primarily relies on independent study to expand his knowledge of co-	• Provide the current SAS with the necessary training and mentoring to fully function in the SAS role, including providing cross-training to other team specialists. • Hire a second SAS with the qualifications to provide individual and group substance abuse treatment to members identified with a co-occurring disorder. •

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			occurring disorders.	
H10	Vocational Specialist on Team	1 – 5 3	The Rehabilitation Specialist (RS) and Employment Specialist (ES) have been in their roles for 21 months and 11 months respectively. Both have limited experience in vocational services related to assisting members with an SMI to obtain employment in competitive setting. No recent training in their roles was found in Relias records given reviewers or identified in staff interviews.	• Ensure both vocational staff members receive ongoing training, guidance, and supervision related to vocational supports and best practices that aid members to obtain competitive positions. Fully integrated ACT teams include vocational services that enable members to find and keep jobs in integrated work settings.
H11	Program Size	1 – 5 5	The size of the team is sufficient to provide coverage. However, two specialist positions and the Psychiatrist position are filled by temporary staff. The second Nurse and second SAS positions are vacant. Staff reported they provide cross-training. However, based on training records, interviews, and observation of the team meeting, it is not clear if specialists receive training related to their assigned roles.	• Provide regular training to specialists so they can effectively provide cross-training to staff. This may help to ensure diversity of staffing to provide services.
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *ACT Admission Screening Tool* developed by the RBHA to assess potential admissions to the team. Staff confirmed they control admissions with no organizational pressures to admit members who the team feels do not meet ACT criteria. Referrals originate from other less intensive teams at the clinic, other providers, or are streamed through the RBHA.	• Provide guidance to the team on how they can actively recruit potential referrals to the team. The current census is less than 90 members.
O2	Intake Rate	1 – 5 5	The ACT team admission rate was low, with less than six members per month. The peak admission rate was two members per month in three of the past six months, one during one month, and zero the other two months.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management services the ACT team has full responsibility for psychiatric and primary responsibility for supportive housing services. No members receive psychiatric services	• Provide on-going training and mentoring to the ES and RS on assisting members in finding and retaining employment in integrated settings. Ensure all staff on the

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			outside the ACT team and less than 10% of members receive any level of case management or housing services from their residences. However, ACT staff do not have full responsibility over other core areas, and function largely as general case managers. Substance abuse treatment and counseling/psychotherapy are provided off the team by an agency psychotherapist (see rationale for Items S7, Individualized Substance Abuse Treatment, and S8, Co-occurring Treatment Groups). ACT vocational staff offer employment groups but appear to concentrate on work readiness and screening programs offered through another agency via unpaid piece work to build employment skills and work adjustment training (WAT). Three members are currently engaged in a WAT, and another had recently been referred. Staff said that they do help members with resumes and job applications, but also reported that a member found a job through a supported employment agency.	team are trained on the benefits of competitive employment in comparison to sheltered work experiences. • It is important that individual and group substance abuse treatments are provided by ACT teams. Hiring a qualified second SAS and providing the current SAS with the necessary training in co-occurring disorders treatment in order to function fully in the role is necessary. All ACT direct service staff should be cross trained in this area in order to support the recovery goals of members identified with a co-occurring disorder. • Consider credentials and qualifications in future hiring to provide counseling/psychotherapy to the ACT members. If the agency opts to use an agency therapist outside the ACT team, it is recommended that this staff participate in at least one program meeting weekly in order ensure proper integration of this area on the team.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour crisis response services, rotating an on-call phone weekly every eight weeks between eight staff. On-call response is available on weekends, and staff will respond in the community to crises. In addition, four staff are assigned to Saturday and Sunday shifts, and are also available for response. The ACT team provides members with a list of staff phone numbers. Members interviewed reported the list of staff and contact numbers was not up to date. The list provided the reviewers included staff who left the team in October 2018; however, the team later provided an updated list. Staff said that members	• As staff transition on or off the team, update the contact sheet and provide to members regularly.

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			rarely call the crisis line, but when they do, the crisis line contacts the ACT on-call and passes the member through to ACT staff.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The ACT team provided the reviewers with information regarding the last ten psychiatric hospital admissions, all of which the ACT team was directed involved. Included among those were ACT initiated amendments to court ordered treatment, responding to crisis calls from members or natural supports, and an incident in which the team coordinated with an out of town crisis team when a member experienced suicidal ideation while visiting family. However, recent admissions appeared to be under-reported. Per staff interview, in at least one case, a member was taken to a psychiatric facility by halfway house staff, and the team was notified later. One staff interviewed said that the team tries to work with members and natural supports to call the team first before seeking hospital admissions so that the team can first assess and attempt to de-escalate using safety planning and coping skills. If this is not successful, staff try to bring the member into the clinic to meet with the Psychiatrist for further assessment and crisis intervention, including medication adjustments. If the psychiatrist determines inpatient admission is warranted, and the member agrees, staff will transport to and remain with the member through the intake. If the member does not agree, the team will evaluate risk and consider petitioning or amending court orders.	• Continue efforts to educate members, natural supports, and system partners to contact the ACT team prior to seeking inpatient psychiatric admissions. The ACT team should be involved in at least 95% of all psychiatric hospital admissions.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	A review of the ten most recent inpatient psychiatric admissions with the CC showed that the ACT team had been directly involved in 100%.	

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			Staff said that discharge planning begins at the hospital admissions. The ACT team begins working with the inpatient social workers about any necessary housing options after discharge. The ACT team helps arrange the communication between the inpatient and ACT Psychiatrist, and the involvement of natural supports. Staff said that they visit members 24 hours after admission and every 72 hours thereafter. Upon discharge, staff transport members home or where they will be living, unless arranged otherwise, and assist them in collecting seven days of medications and follow up appointments with the Psychiatrist and their PCP. The agency's discharge protocol calls for face-to-face daily contact with members for four weeks either at the clinic or the member's home.	
O7	Time-unlimited Services	1 – 5 3	The ACT team uses an exit criteria provided by the RBHA. Data provided the reviewers showed that the ACT team graduated nine members in the last 12 months. In addition, the reviewers were told that another 11 members were stepped down to a lower level of care per instructions from the RBHA because claims data indicated that they no longer needed the intensity of ACT services. Staff said that the team was given a list of members that RHA deemed ready for step down; two of those members were remained with the ACT team due to subsequent psychiatric hospitalizations. Staff agreed that some of the stepped down members appeared ready for graduation. Members who were stepped down were notified in advance of the plan and agreed to it. Staff reported that they anticipate graduating about six members in the next year, and that the RHBA has given the team a list of another 10 members to be stepped down, for a combined estimate of 18%.	• The team should work toward maintaining an annual graduation rate of fewer than five percent of the total caseload. • As with admissions to the team, ensure ACT teams are empowered to work with members to determine whether they are appropriate for ACT services and ready for graduation.

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			Staff said that to prepare members for graduation or step down, they begin with a discussion with the member about their feelings about leaving the team. There is a gradual reduction in services and transition to a supportive team. Staff said that some members expressed not being ready to leave the team and the team does not want to move them faster than they feel comfortable.	
S1	Community-based Services	1 – 5 1	Staff interviewed estimated between 60% - 100% of face-to-face member contacts occurred in community settings. However, a review of ten member records showed community-based contacts occurred 19% of the time. Three records reviewed showed only office contacts; two records showed zero face-to-face contacts for the period reviewed.	• Provide ACT direct member services to members in the community 80% or more of the time. Community-based, rather than office-based, treatment allows members to learn new skills and behaviors where challenges are more likely to occur. In the community, staff can directly assess, monitor progress, model behaviors, and assist members to use resources and natural supports.
S2	No Drop-out Policy	1 – 5 5	The ACT team rarely closes members for lack of contact. If outreach efforts are not successful in locating members, they are transferred to navigator status for ongoing outreach. Staff identified three members who were transferred to navigator status. One member relocated out of state without notifying the team; a family member informed the team of his whereabouts and that the member had enrolled in services. The ACT team offers referral assistance when members leave or plan to leave the area; one member set up services herself over a phone in the ACT office, and another accepted the team's assistance with an out-of-state referral. Two members were closed due to the team's inability to serve: one who was transferred to Arizona Long-Term Care	

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			Services (ALTCS) and another to the Department of Corrections.	
S3	Assertive Engagement Mechanisms	1 – 5 2	Staff provided an outreach checklist found on the *Change of Level of Care/Navigator Panel* form. Outreach is tracked weekly for eight weeks. The document provided general guidelines for staff to complete phone calls and other office-based efforts. Two homes visits are prompted over the course of the entire eight week outreach period. The checklist does not prompt for street outreach efforts. In records reviewed, there were multiple examples of lapses of a week or more when staff did not have contact with members.	• Monitor outreach and engagement for members who are not in contact with the team or do not frequently visit the clinic. Ensure specific plans for outreach with staff responsible are identified (e.g., during the team meeting). • Ensure community-based efforts occur and are documented. Consider following the RBHA ACT Manual guidelines when performing outreach, which requires four outreach attempts weekly, including two community-based efforts.
S4	Intensity of Services	1 – 5 2	The median intensity of face-to-face service time spent per member was 17 minutes based on review of ten member records. Some members received medication observation services. One outlier of the ten members received an average of 142 minutes of ACT service time per week over a month timeframe. Two members received zero minutes of services.	• The ACT team should provide members an average of two hours of face-to-face contact weekly. Intensity may vary based on where the member is in recovery, but an average of two hours across members on the team should be the goal.
S5	Frequency of Contact	1 – 5 2	The median weekly face-to-face contact for ten members was 1.25 based on review of member records. Only two members received an average of four or more contacts weekly. The majority (eight of ten) of those members received two or fewer contacts on average per week over a month timeframe.	• Increase the frequency of contact with members by ACT staff to average four or more per week, and ensure all contacts are accurately documented.
S6	Work with Support System	1 – 5 2	Staff reported the plurality of members have informal/natural supports. Staff reported that they attempt to have at least weekly contact with natural supports. Based on ten member records reviewed, the ACT team has infrequent contact with informal (i.e., natural) supports, less than	• Encourage members to identify natural supports. Discuss with them the benefits of involving their supports in their treatment. Staff may benefit from training and guidance on new strategies to engage members in discussions of their natural

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			once (.5) on average, per month. Staff infrequently referenced contact with informal supports during the morning meeting observed.	supports and how to interact with those supports once identified. • Ensure staff accurately document informal/natural supports in the member record.
S7	Individualized Substance Abuse Treatment	1 – 5 1	The ACT team does not offer individual substance use treatment. A small number of members meet with a counselor at the office who is not a staff person on the ACT team. Staff seemed uncertain of the exact number of members who meet with that counselor. The team has a staff in the position of SAS, but it does not appear that the staff receives regular training and education to effectively fulfill the expectations of the position.	• Across all members with a co-occurring disorder, an average of 24 minutes or more of formal structured individual substance use treatment should be provided weekly. ACT SASs should be trained and receive guidance on how provide individual substance use treatment. Licensure is beneficial, but not required, to provide substance use engagement and treatment. • Engage members to participate in regularly occurring individual substance use treatment with ACT staff.
S8	Co-occurring Disorder Treatment Groups	1 – 5 1	The ACT team currently offers no co-occurring treatment groups. Group treatment is available only through a counselor at the office who is not a staff on the ACT team. Staff seemed uncertain when or how often the group meets, as well as the exact number of members who attend groups with that counselor.	• ACT SAS staff should be trained and receive guidance on how to facilitate substance use treatment groups. • Engage members with a co-occurring diagnosis to participate in treatment groups based on their stage of treatment. Optimally, at least 50% of dually-diagnosed members should attend at least one treatment group monthly. • Consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 2	Staff do not appear to recognize their role in co-occurring disorders engagement or treatment. The SAS appears to function in the role of a general case manager rather than a core area specialist.	• Provide training and ongoing supervision to SASs. Empower SASs staff to provide individual and group substance use treatment. Licensure is beneficial but not

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			The reviewers saw no evidence that the team practices from a dual diagnosis integrated treatment approach. The team appears to have relied primarily on the SAS who departed the team late October 2018 to address substance use issues with members. Staff were not familiar with stage-wise treatment. During the meeting observed, member substance use challenges were mentioned infrequently. The reviewers identified less than five instances of staff recently engaging members to address substance use issues. The engagement appeared to focus on connecting members with the counselor who is not a staff on the ACT team. Staff interviewed reported the team is cross-trained. Staff reported they assess members' stages of change at least annually. Staff said they use American Society of Addiction Medicine (ASAM) criteria to assess members. There was no evidence of stages of change discussed in the morning meeting observed. No evidence was found in member records reviewed that the ACT team was directly addressing substance use challenges with those members with a substance use diagnosis. Treatment plans contained limited detail regarding substance use treatment interventions provided by ACT staff. There were infrequent documented examples of engaging members to participate in substance use treatment. When documented, it appeared to focus on offering groups or treatment with the counselor who is not a staff on the ACT team.	required to provide substance use engagement or treatment. • Provide training to all staff on an integrated approach to substance use treatment. Having a common treatment approach should benefit the members served. • Review with staff the benefits and drawbacks of referring members to AA or similar groups. Review with staff the conditions when withdrawal management may be medically indicated. • Ensure all staff work from a harm reduction approach. Train staff on harm reduction tactics. Train staff how to incorporate interventions in treatment plans and notes. • As noted earlier in the report, offer multiple co-occurring treatment groups to serve members in various stages of treatment and hire a second SAS staff.

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			Staff reported the focus of treatment was on helping members abstain. Staff also said the team works with members to find ways for them to reduce use. Staff reported they utilize harm reduction tactics. One staff said the team offers meetings and detoxification. Staff reported that they refer members to Alcoholics Anonymous (AA) and detoxification facilities. It was not clear if staff were aware of specific substances that may require medical withdrawal management support. One reported those substances include opiates but also methamphetamines.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has a full-time Peer Support Specialist (PSS). The PSS is a family member of a person with lived experience. Staff interviewed reported there is also a staff on the team with direct lived experience of psychiatric recovery. Per report, the staff with lived experience discloses to members when appropriate. The PSS and the staff with lived experience have equal responsibilities to all the other team staff.	
Total Score:		**3.21**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	1
6. Staff Capacity	1-5	4
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	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	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	3
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	1
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	2
4. Intensity of Service	1-5	2
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	**3.21**	
Highest Possible Score	**5**	