ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: July 29, 2019

To: Chelsea Heintz, ACT Clinical Coordinator
Dr. Diane Papke
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AHCCCS Fidelity Reviewers

Method

On July 10-11, 2019, TJ Eggsware and Karen Voyer-Caravona completed a review of the Terros Health Priest Drive Recovery Center 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.

Terros Health offers services that include: primary medical, wellness care, mental health care, addiction treatment and counseling. The agency operates multiple recovery centers in the Central Region of Arizona. The agency operates four ACT teams, one of which is located at the Priest Drive Recovery Center, the focus of this review.

The individuals served through the agency are referred to as *clients* or *behavioral health recipients (BHR)*, 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 team meeting on July 10, 2019;
- Individual interview with the ACT Clinical Coordinator (i.e., Team Leader);
- Individual interviews with the Housing Specialist (HS), Substance Abuse Specialist (SAS), and Independent Living Skills Specialist (ILS);
- Group interview with four members who receive services from the team;
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of documents, including: the Regional Behavioral Health Authority's (RBHA) *ACT Eligibility Screening Tool* and *ACT EXIT Eligibility Criteria Screening Tool*, Clinical Coordinator (CC) face-to-face tracking log, substance use group sign-in sheets, substance use treatment resources, the team's *ACT Outreach and Engagement* checklist, team contact information document, and resumes for the SASs and Rehabilitation Specialist (RS).

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The members interviewed shared positive feedback on the current ACT staff and the support they provide.
- Staffing is of sufficient size to provide necessary coverage to the 99 members served. The team is staffed with ten direct service staff.
- The team is staffed with a Psychiatrist and two Nurses. Interviewees reported that the Psychiatrist and Nurses are accessible and provide community-based services. Members said that the Psychiatrist takes the time to listen and explain things to them.
- The ACT team provides crisis support to members. Members interviewed confirmed team availability after business hours and that staff provided to them a document with staff names and contact numbers. A current version was provided to the reviewers.
- The team maintained a low admission rate, and few members transitioned off the team over the year prior to review.

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

- Evaluate employee's motives to maintain employment with the team and factors that contribute to turnover. Consider asking current ACT staff about what retention efforts they might be receptive to and how the agency can support them in their roles. The team experienced a staff turnover rate of about 67% in the past two years. Ideally, turnover should be less than 20% over a two-year period.
- Maintain regular contact with members and their support networks which might result in the identification of issues or concerns that could lead to hospitalization. There were lapses in documented contact with members prior to, during, and after inpatient stays in certain records reviewed.
- Provide the majority of services to members in their communities, optimally 80% or more. Documentation in sample records reviewed showed many services occur in the office. Some members elect to participate in clinic-based groups. For members who prefer not to participate in clinic-based activities, accommodate their preference and engage them in their community.
- Increase the intensity of services and frequency of contact with members by ACT staff. Work with staff to identify and resolve barriers to increasing the frequency of contact and intensity of services to members.
- Increase engagement of natural supports as partners in supporting members' recovery goals. Training staff on informal support engagement strategies may be helpful. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or utilize recovery language when they interact with members.
- Provide training to staff on stage-wise treatment, associated interventions, and strategies to engage members in individual and/or group treatment. Some agencies have purchased and distributed to ACT teams treatment manuals and resources to ensure staff draw from the same information. Both SASs should receive supervision so they can cross-train other specialists in substance use treatment.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team serves 99 members with nine staff that provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of 11:1.	• Fill vacant positions with qualified staff as soon as possible to maintain a small caseload ratio.
H2	Team Approach	1 – 5 3	Staff said they have caseloads for annual paperwork purposes, but otherwise serve all members. Members interviewed were familiar with specialty staff on the team and reported receiving contact from multiple staff weekly. Some of the members frequently attend clinic activities. One staff said all members likely receive face-to-face contact with more than one staff over a two-week timeframe. Staff said this is tracked during daily team meetings and electronic reports of staff contacts. Based on sample records reviewed, 40% of members received face-to-face contact with more than one staff over a two week period.	• Evaluate the current contact strategy and tracking mechanisms to ensure implementation as intended. Confirm that attempts and successful contacts are documented in a timely manner. Ideally, at least 90% of members have contact with more than one staff over a two week period.
H3	Program Meeting	1 – 5 5	Staff said that the program meeting is scheduled for one hour five days a week. On Wednesdays the meeting is extended for an hour to coordinate on paperwork or related tasks. Staff attends meetings on the weekdays they are scheduled to work. During the meeting observed, the team discussed all members. Staff discussed their contacts with members that occurred up to about a week prior to the meeting date. Staff attributed the reporting of contacts for about a week prior to the meeting was due to a holiday the prior week and staff vacations.	
H4	Practicing ACT Leader	1 – 5 3	The CC estimated spending about 50% of her time providing direct services. However, few examples of direct services by the CC were found in ten member records. Over a month timeframe, one office-based contact with a member was documented. For another member, the CC	• Identify and address barriers to the ACT CC providing at least 50% of the time in direct services. If new staff joins the team, supervision might include the CC mentoring them as they deliver services, preferably, in the community.

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			documented an attempted community visit. Other CC notes documented coordination with stakeholders. The CC's production report over a month showed that direct services were provided to members nearly 15% of the time.	
H5	Continuity of Staffing	1 – 5 3	There was staff turnover during the recent two-year timeframe. Data showed that nine staff left the team, in addition to three Psychiatrists who provided coverage on the team, resulting in a 50% turnover rate. Multiple staff filled the SAS role.	• When possible, examine employees' motives for resignation, and attempt to identify other causes for employee turnover. Optimally, turnover should be less than 20% over a two-year period. Consistent staffing is a key ingredient in successful ACT teams.
H6	Staff Capacity	1 – 5 4	The team operated at nearly 85% of staff capacity over the past year. There was a total of 22 months with position vacancies.	• Fill vacant positions with qualified staff as soon as possible.
H7	Psychiatrist on Team	1 – 5 5	Staff said that the full-time Psychiatrist is an active team member and is available to staff to discuss issues as they arise, including after hours and over the weekend. Members said that the Psychiatrist takes time to listen and explain things to them, such as the potential effects of medications. The Psychiatrist works four ten hour days attending meetings on those weekdays. Staff said that the Psychiatrist provides community-based services one day weekly; visiting members while inpatient, in their homes, and in the community. In the records reviewed, there were examples of the Psychiatrist providing community-based services.	
H8	Nurse on Team	1 – 5 4	There are two full-time Nurses assigned to the team. Staff reported that the Nurses are accessible and responsive. Both work four ten-hour days and attend the team meeting on the weekdays they are scheduled to work. Staff said both Nurses provide community-based services, and examples were documented in records reviewed. One	• This team has nearly 100 members so ideally two full-time Nurses are assigned who have no administrative duties outside of the team.

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			Nurse's schedule includes Saturday coverage. One Nurse is the lead Nurse for the clinic. Staff said that that Nurse's time is primarily spent providing ACT services, but it appears a portion is spent in tasks related to the lead role.	
H9	Substance Abuse Specialist on Team	1 – 5 4	Substance abuse treatment is provided by the ACT Counselor (AC) and the SAS. The AC has more than one year experience in substance use treatment. Staff said that the AC receives weekly individual supervision from a licensed professional. The SAS joined the team March 2018 and transitioned to the role in December 2018. The SAS's resume showed a variety of social service positions, including on other ACT teams. However, it does not appear prior specific experience providing co-occurring treatment to members was acquired and training records showed few relevant sessions.	• Provide both SASs with supervision and training in co-occurring treatment best practices. This may better equip SASs to cross train other staff in appropriate interventions based on members' stages of treatment.
H10	Vocational Specialist on Team	1 – 5 3	The team employs one RS. The second Vocational Specialist (VS) equivalent role, the Employment Specialist (ES), is vacant. The RS joined the team in June 2017 as the ACT Specialist and transitioned to the current role in April 2019. The RS's resume showed experience assisting individuals with employment goals prior to joining the ACT team.	• Seek to fill the second VS position with someone who has experience helping members to obtain competitive positions in integrated work settings. Ideally this staff should have experience with job development, supporting individualized job searches, and follow-along support.
H11	Program Size	1 – 5 5	At time of review, with ten direct service staff, the team is of sufficient size to provide coverage.	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported that referrals originate from other teams at the clinic, other providers, or through the RBHA. The CC meets with the potential new member to complete the RBHA's screening tool and then meets with the Psychiatrist to discuss the findings. The Psychiatrist makes the final decision if members join the team. Staff said that other than occasional administrative transfers of	

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			members from other ACT teams, there are no external mandates to accept admissions. Staff reported no administrative transfers the past year.	
O2	Intake Rate	1 – 5 5	Member admissions to the team over the prior six months peaked at three during the months of February and March 2019. There was one admission each month during April and May 2019 and zero during January and June 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides case management, psychiatric services, individual and group substance use treatment, most housing support, and psychotherapy/counseling is available. Members interviewed said that there are specialists on the team who can assist with housing, employment, and other services. Psychotherapy/counseling is available through the AC. Interviewees reported certain members receive counseling from outside providers. Staff said this was due to the members working with those counselors before joining the ACT team. Some notes in member records presented detailed information on how certain staff assists members to enhance their skills to maintain housing (e.g., budgeting). Staff estimates of members who reside in staffed residences ranged from 4-8% and the descriptions of the types of staffed settings varied. One staff identified a higher number of members in community living placements than another staff who identified more members who resided in half-way house settings. One staff reported members who receive flex-care treatment, but others reported zero members in those settings. During the morning meeting there	• Ensure staff are familiar with the types of independent, staffed or treatment settings where members reside. • Ensure service staff is aware of their role regarding educating and supporting members to follow terms of leases or housing agreements. Optimally, service staff is not expected to report lease or living agreement infractions to housing management. Service staff can advocate with, and on behalf of, members to assist them to maintain tenancy. • Optimally, ACT services include vocational services and can directly assist members to obtain and maintain employment. Evaluate what services external providers offer that ACT cannot provide. • To support staff retention, ensure staff receives training and supervision for their specialty.

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			was discussion of possibly reporting a member's behavior in their residence to a housing manager. Training records showed staff participated in supported employment and Disability Benefits 101 (DB101) trainings. Interviewees reported staff helps members with employment goals. However, it appears more than 10% of members receive employment support services from an outside agency. In records, certain members discussed employment goals and resources, but it was not clear if staff offered options to assist them directly.	
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported that the ACT team is available to provide crisis services. There is an on-call and some staff work weekend hours. The on-call staff contacts the CC if they need to meet with members in the community after hours. Staff provides to members a document that includes the on-call and staff phone numbers with brief descriptions of how specialists can be of assistance. Members interviewed confirmed that the team is available after business hours. Though, one staff documented in multiple records that members were aware of urgent care crisis services and the county warm-line for emergent situations.	• Ensure all staff conveys to members that ACT staff is available as the first line of contact for crisis intervention, including over the weekend and after hours.
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff said that if a member requests inpatient services, staff will arrange for members to meet with a Psychiatrist and/or Nurse before inpatient treatment during business hours. After hours or on the weekend, on-call staff is available. Staff transport members and stay with them until they are admitted to the inpatient setting. Staff said that some members seek inpatient treatment without informing the team. Based on information provided, the ACT team was directly involved in	• Maintain regular contact with all members and their support network. This may result in the identification of issues or concerns that could lead to hospitalization. Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions. • When members do not involve the team prior to an admission, seek to identify the

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			half of the ten most recent hospital admissions. Staff said three members self-admitted and one was petitioned by police. For one admission the fifth member elected to involve a natural support, declined team involvement, but later involved the team for a second admission.	reasons or circumstances. To the extent possible, develop plans with the members and support systems so the team can demonstrate how staff can offer support.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff said that the ACT team is always involved in member hospital discharges, including the ten most recent. Staff said the Psychiatrist usually makes doctor-to-doctor calls to inpatient providers each Friday. Staff reported that an ACT staff meets with members within 24 hours of an admission and then on Monday, Wednesday and Friday thereafter. Per report, staff coordinates with hospital staff and participates in discharge planning meetings. Staff said that the team meets members at discharge to provide transportation to their discharge setting, but on occasion family picks up the member. Ideally the member meets with the Psychiatrist on the day they discharge, but an appointment must occur within 48 hours. Staff said the team completes five consecutive days of face-to-face contact with members after discharge. In records there were multiple lapses in documented staff contact with members while inpatient and following discharge. Gaps in documented visits with members while they were inpatient ranged from four days after admission up to nine days while inpatient.	• Evaluate the discharge process the team follows. Ensure all staff is familiar with and follow the process. Ensure all outreach and contacts are documented. Discuss recent contact, planned contact, and discharge plans during the team meeting.
O7	Time-unlimited Services	1 – 5	Staff said one member graduated from the team over the past year and that none are in process or	

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		5	projected to graduate in the next year.	
S1	Community-based Services	1 – 5 2	Staff reported they spend 80% of their time in the community. In ten member records reviewed, a median of 27% of services occurred in the community. Staff documented attempts to visit members, but it was not always clear if community-based visits were planned ahead with members. Most members interviewed reported they met with staff more often at the office and one reported a mix of office and community contacts. Documentation showed members are often encouraged to participate in groups. However, there was at least one example of staff encouraging a member to engage in activities in the community where the member resided.	• Evaluate barriers to increasing community-based services. Identify and consider eliminating non-essential activities that result in staff needing to spend time in the office versus the community. ACT teams should perform 80% or more of contacts in the members' communities where staff can directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting. Engage members in the community at a similar level as what was reported by staff interviewed.
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the prior year, the team retained about 97% of members. A member moved to another area in Arizona and declined assistance from the team to transition to a provider. Another member elected to end ACT services, was offered a lower level of service, and ultimately transferred to Navigator status. The third was not responsive to team engagement, elected to end ACT services, and transitioned to Navigator status. One staff was uncertain if members could voluntarily end ACT services.	• Review with staff if/when members can elect to end ACT services.
S3	Assertive Engagement Mechanisms	1 – 5 2	Staff said when members are not in contact with the team, outreach occurs for eight weeks. The process begins when a member misses an appointment. Staff provided a copy of the checklist the team follows titled *ACT Outreach and Engagement* that has space to track up to four outreach efforts per week. The checklist prompts staff to conduct community-based outreach at least twice weekly for five of the eight weeks, in	• Monitor contacts with members. Ensure staff document in records attempted and completed member contacts. For example, it may be useful to assign one staff (e.g., Program Liaison) to review documentation in member records during the team meeting to confirm recent contacts occurred so that the team can proactively assign staff to outreach in the event of

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			addition to office-based efforts. In ten member records reviewed, there were gaps in documented community-based outreach or contact of a week or more, for eight members, over a month timeframe. Some members missed appointments, but it was not clear if follow up occurred on a timely basis. However, an example was found of a member who did not attend two appointments with one of the Nurses. On both occasions, the Nurse called the member and rescheduled the missed appointments, but subsequent contact or outreach by other ACT staff was not found in the record for about six days. In two records, staff submitted amendment documents for members who were under a court order for treatment (COT) to adhere to medications. There was limited evidence of outreach preceding or subsequent to the letters.	lapses. • Consider enhancing the eight week checklist to prompt for more variety in community-based outreach. As a first step, prompt for at least two community-based outreach attempts per week, in addition to the office-based or other telephonic activities. • The team may benefit from training on their role and responsibilities when members are required to participate in treatment due to a COT. Review what type of outreach should occur if members do not attend appointments, etc. and how supervisors should confirm outreach or engagement occurs.
S4	Intensity of Services	1 – 5 2	Based on review of ten records, the median intensity of face-to-face service time per member was less than 42 minutes weekly. Member participation in groups led by non-ACT staff was not factored for this item as only services delivered by ACT staff is considered. Similarly, progress notes entered by staff when members did not attend clinic-based groups were not factored. During the team meeting staff reported on contacts with members and the time of the service.	• Work with staff to identify and resolve barriers to increasing the average intensity of services to members. The ACT team should provide members an average of two hours of face-to-face contact weekly. • Monitor face-to-face contacts with members for accurate documentation. Consider assigning a staff to check recent contacts during the team meeting. Tracking documented face-to-face service time per member might help the team to identify those members with less contact.
S5	Frequency of Contact	1 – 5 2	Members interviewed reported frequent contact with staff. Some staff interviewed said they meet with many members, 70-75%, during a recent	• Work with staff to identify and resolve barriers to increasing the frequency of contact with members, preferably

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			week. Staff estimates of their contacts with members were higher than the results of ten member records reviewed. A median weekly face-to-face contact of just over 1.6 was found in the records. Some single staff contacts with members were documented in more than one note if multiple activities occurred. For this review, those contacts were considered as one contact. Member contacts by non-ACT staff were not factored. Some members attend groups led by other clinic staff.	averaging four or more face-to-face contacts a week per member. Ensure contacts and attempts are documented. • Seek to replicate the frequency of contact reported by interviewees with those members who do not frequently attend clinic groups or live in ACT affiliated housing where staff visits often. Not all members elect to participate in office-based groups and may be receptive to individualized support in the community.
S6	Work with Support System	1 – 5 2	Staff estimates of members with informal supports were a low of 20% and a high of 85% to 90%. Staff said they attempt contact with informal supports weekly. Some members interviewed confirmed staff has contact with their natural supports or would make contact if requested. Staff said a family group is offered, but is not well attended. One staff attributed this to the group occurring in the afternoon on a weekday. During the team meeting, staff discussed contact with informal supports, or plans to attempt contact natural supports, for 15 members. In ten records, there were few documented contacts with informal supports over a month timeframe, resulting in an average of less than one contact per member.	• The team may benefit from further training on strategies to assist members in building and engaging natural supports. Discuss with members the benefits of involving their supports in their treatment. • Educate informal supports about how they can support members' recovery. For example, assist them to identify community-based activities they can engage in with members. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or model use of recovery language.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff identified 51 members with a substance use diagnosis. Staff said that the SASs coordinate those members' services, and both SASs provide individual treatment to 36 of those members, most of whom receive weekly treatment. The SASs Outlook calendars for a recent month were provided. The calendars seemed to identify scheduled appointments with members and not	• Offer individual treatment to members with a co-occurring diagnosis. Train staff on strategies to engage members in substance use treatment. Individualized treatment may be more appropriate for members in earlier stages of treatment. • Continue all efforts to increase the time spent with members in individual sessions to 24 minutes or more, per applicable

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			completed contacts. Ten member records were reviewed, and five of those members had a substance use diagnosis. Per the calendars, examples were found of members scheduled without a corresponding note in the records. There were two examples of completed individual sessions in the ten records reviewed; one four minute and one 30 minute contact.	member. • Ensure that both SASs receive the necessary training, mentoring, and ongoing guidance to provide structured, individual substance use counseling. Ensure other specialists, in addition to the SASs, inform members of individual treatment available with the SASs.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	Each SAS offers a substance use treatment group. Staff said that ACT members do not attend substance use treatment groups with other staff at the clinic or with outside providers. There were examples in member records of staff inviting members to attend group treatment. Based on sign-in sheets, over a month timeframe, about 20% of members with a substance use diagnosis attended group at least once. Some members attended multiple groups over a month timeframe. The CC facilitated one of the groups.	• Continue to engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring treatment group. • Ensure that the SASs and any other staff who facilitates group treatment receive the necessary training and ongoing guidance to provide structured substance use group treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Training records showed some staff participated in Integrated Dual Diagnosis Treatment (IDDT), stages of change, American Society of Addiction Medicine (ASAM) training, or motivational interviewing, which was the most common training across staff records provided. There was an example of a staff who participated in medication assisted treatment training. An interviewee said that an independently licensed professional conducts clinical oversight with the clinic staff one to two times a month. Staff said that the AC provides training to the team on topics that include stage-wise, IDDT, and motivational interviewing. Those team specific trainings would not be captured on training records provided.	• Provide training to all staff on an integrated approach to substance use treatment, including a stage-wise approach (i.e., engagement, persuasion, active treatment, and relapse prevention). • If it has not occurred, review training records to ensure all staff participated in applicable substance use treatment trainings available. Individual or group trainings can then help to expand their knowledge. Having a common treatment approach should benefit the members and help staff to align their activities appropriately. Not all staff that join the team have prior experience in providing substance use treatment to adults.

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			Staff gave examples of recent harm reduction efforts, including seeking solutions with members to lessen use of a substance, to find safe shelter, or involving natural supports. The team does not directly refer to Alcoholics Anonymous (AA) or similar groups, but some members elect to participate in those supports. Staff reported that members known to use alcohol or opiates may be referred for withdrawal management (i.e., detoxification) after an assessment by a team Nurse or the Psychiatrist. Based on interviews and observation, it does not appear all staff are familiar with stage-wise treatment, but seem to be familiar with stages of change. In some applicable records, substance use was discussed, but it appeared identifying coping skills was a primary area discussed. Other staff activities were somewhat less detailed. Certain applicable treatment plans referenced substance use, but did not include specific services to address the issue. Some plans captured more general information rather than individual services. The needs listed were incomplete on some plans, ending mid-sentence, which seemed to be a feature of the electronic format.	• Review with staff to ensure accurate documentation of services on treatment plans. This may include referencing substance use treatment by a SAS (if members agree), staff activities based on a member's stage of treatment, and individualized plans.
S10	Role of Consumers on Treatment Team	1 – 5 5	Interviewees confirmed there is an employee on the team with personal lived experience of mental health recovery. Some staff reported that, when appropriate, the staff with lived experience discloses to members.	• Ensure member voice is represented on the team. Not all staff were aware if there is staff on the team with direct personal lived experience of psychiatric recovery.
Total Score:		**3.75**		

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	3
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	4
9. Substance Abuse Specialist on Team	1-5	4
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	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	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	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.75**	
Highest Possible Score	**5**	