ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 7, 2019

To: Tiffany Covington, Clinical Coordinator – ACT
John Hogeboom, President/CEO

From: T.J. Eggsware, BSW, MA, LAC
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AHCCCS Fidelity Reviewers

Method

On October 21-22, 2019, T.J. Eggsware and Annette Robertson completed a review of the Community Bridges, Inc. (CBI) - 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 the Central Region of Arizona.

Community Bridges, Inc. (CBI) operates several locations throughout Arizona. Services include supportive housing, crisis stabilization, ACT, and integrated healthcare. The agency operates three F-ACT teams and three ACT teams in the Central Region of Arizona. Operational management of the Mesa Heritage location transitioned from another provider to CBI during May 2018.

The individuals served through the agency are referred to as *patient*, *client* 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:

- Observation of a team meeting on October 21, 2019;
- Individual interviews with the ACT Clinical Coordinator (i.e., Team Leader), a Substance Abuse Specialist (SAS), Peer Support Specialist (PSS) and, a Nurse;
- Group interview with five members who receive ACT 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: Clinical Coordinator (CC) face-to-face service tracking report, staff resumes, substance use group sign-in sheets, substance use treatment resources, eight week outreach tracking sheet, formal support contact lists, and, the Regional Behavioral Health Authority (RBHA) *ACT Eligibility Screening Tool*, *ACT EXIT Criteria Screening Tool*, and *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual*.

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 ACT team meets five days a week to discuss members. During the team meeting observed, multiple staff contributed to discussions.
- Some staff work weekend, early morning or evening hours.
- The team is staffed with two Nurses who share in the provision of office and community-based services to ACT members.
- The team maintained consistency and continuity of care for members over the prior year, with a low admission rate and zero dropouts.

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

- Continue efforts to recruit and retain qualified staff. The members experienced significant staff turnover in the prior two years, including the period when the Mesa Heritage location transitioned from another provider to CBI during May 2018. Current staffing is insufficient to provide necessary coverage.
- Ensure position specific training and supervision is available to specialists. Specialists appear well-positioned to fulfill their roles, but based on resumes and training records, not all attained requisite experience.
- Evaluate what prevented staff from directly supporting members during hospital admissions. Based on information provided, the ACT team was involved in three of the ten most recent hospital admissions. Five members self-admitted at other CBI crisis stabilization facilities and two members self-admitted at facilities not affiliated with CBI.
- Consider implementing a comprehensive co-occurring treatment model. The team draws from multiple treatment resources with likely beneficial elements, but there may be more effective approaches available for individuals with co-occurring SMI and substance use diagnoses. Ensure individual and group treatment is offered to members with co-occurring diagnoses. Evaluate the content of the substance use treatment groups to ensure the use of a co-occurring treatment approach.
- Increase engagement with 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.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team serves 97 members with nine staff that provide direct services, resulting in a member to staff ratio of 11:1.	• Optimally, the member to staff ratio does not exceed 10:1. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 – 5 4	One staff said that, with exception for incarcerated members, 100% of members receive face-to-face contact with more than one staff over a two-week time frame. Based on sample records, 80% of members received face-to-face contact with more than one staff over a two-week period.	• Confirm that attempts and successful contacts are documented. Ideally, 90% or more members have contact with more than one staff over a two-week period.
H3	Program Meeting	1 – 5 4	Staff said that all members are discussed during the team meeting, held five days a week, Monday - Friday. On Wednesdays the meeting is longer in duration to allow for more in-depth discussion of members facing complex challenges. Specialists attend on the days they are scheduled to work, but the primary part-time Psychiatrist does not attend. One staff reported that they can contact a Psychiatrist to discuss certain members via videoconference during the team meeting, and another staff said that covering Psychiatrists attended meetings one time.	• The Psychiatrist should attend for the full duration of the team meeting at least once per week.
H4	Practicing ACT Leader	1 – 5 3	The CC reported providing direct services about 50% of the time. In ten member records there were few examples of services delivered by the CC over a recent month. Based on review of the CC's productivity report over a month time frame, the CC provided direct services 28% of the time. However, in addition to direct services, the report appears to include phone contacts based on comparison to sample records.	• Optimally, CC's delivery of direct services to members should account for at least 50% of the time and be documented in the members' records.
H5	Continuity of Staffing	1 – 5 1	The members experienced considerable staff turnover in the prior two years, more than 80%. Data is not available regarding staff who left the	• Continue efforts to recruit and retain experienced staff. Attempt to identify causes for employee turnover. Optimally,

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			team October 2017 through May 2018. Staff reported that few ACT staff transitioned from the prior provider to CBI during May 2018. Based on data provided, since May 2018, 11 staff left the team. Staff said that employees from other agency ACT teams provided coverage when the team was not fully staffed, including multiple psychiatrists.	turnover should be no greater than 20% over a two-year period. Ensure staff receives training and guidance applicable to their specialty position. Research shows staff remain in positions longer when supported in their roles.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 81% of staff capacity over the prior year. There was a total of 28 months with position vacancies. Positions vacant for multiple months in the past year include: ES, SAS, ACT Specialist, Nurse, Psychiatrist, and Independent Skills Specialist.	• When applicable, fill vacant positions with qualified staff as soon as possible. In an effort to support retention, ensure staff receive training and supervision for their specialty.
H7	Psychiatrist on Team	1 – 5 3	Multiple Psychiatrists provided coverage to the team over the prior 12 months, the longest period with one Psychiatrist occurred February 2019 through August 2019. Staff said one Psychiatrist is available to the team two days, or about 15-20 hours per week, to provide videoconference services. The Psychiatrist does not attend full team meetings and some staff have limited interaction with the Psychiatrist. In sample records, notes show services provided by three Psychiatrists over a month. Due to no permanent full-time Psychiatrist, the Nurses coordinate appointments with the covering Psychiatrists. To maintain continuity of care for members, the Nurses make an effort to arrange for a member's appointments with the same Psychiatrist. If urgent issues arise, members receive service from different Psychiatrists depending on the weekday. A staff highlighted the benefit of a, preferably in-person versus telemedicine, consistent Psychiatrist. Some interviewees said that there are members who prefer in-person Psychiatrist service over	• ACT teams should have at least one full-time, fully integrated Psychiatrist assigned to serve as the medical director for the team. Continuity supports therapeutic relationships between the member and the prescriber, and helps develop team cohesion.

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			videoconference contact.	
H8	Nurse on Team	1 – 5 5	Two full-time Nurses are assigned to the team. Both Nurses work four ten-hour days and attend team meetings on those weekdays. Staff reported that the Nurses are accessible and responsive, including over the weekend and after hours. Examples of the Nurses providing services to members in the community were found in records. Staff said that the Nurses rarely provide services to members served by other teams at the clinic.	
H9	Substance Abuse Specialist on Team	1 – 5 4	The team has two SASs. One, classified as a Substance Abuse Counselor (SAC), was an intern on the ACT team for 20 hours a week July 2018 through May 2019 prior to completing a master's degree program in counseling in May 2019 and then joining the team full-time, with no other experience providing co-occurring substance use treatment. The second SAS, a Licensed Master of Social Work (LMSW), joined the team December 2018. The second SAS has more than a year of experience providing co-occurring treatment including time on the team and in prior positions. Training records for the SASs showed one participated in no substance use treatment training and the other participated in at least two treatment specific sessions. Staff said that the SAS's receive weekly supervision, each with a different licensed professional: a Licensed Clinical Social Worker, and a staff who is both a Licensed Professional Counselor and a Licensed Independent Substance Abuse Counselor.	• Continue to provide SASs with supervision, training, and guidance in co-occurring treatment. If it has not occurred, the two supervisors of the SASs may consider coordinating the topics covered. Optimally, consistent evidence-based co-occurring treatment information is provided. SASs may then be better equipped to cross-train other staff on the team if they adopted a co-occurring model.
H10	Vocational Specialist on Team	1 – 5 1	The team employs an ES who joined the team September 2019. Based on staff interviews, the vocational staff is engaging members and available to assist with resume development, job searches,	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met.

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			and to support social and employment goals. Training records for the vocational staff show participation in employment related topics, but few that seem specific to service delivery. For certain topics, it is unclear if the sessions were directed at the staff's job duties at the time with another provider or related to how to deliver employment support services to members. The staff's resume from the same timeframe did not illustrate the staff assisted members with employment services.	• Provide training, guidance and supervision to vocational staff related to vocational supports and best practices that aid members in obtaining competitive positions.
H11	Program Size	1 – 5 4	At the time of review, with nine direct service staff, and part-time Psychiatrist coverage, the team is less than optimal size.	• Seek to recruit and retain qualified staff. Ideally, ten or more staff works on an ACT team.
O1	Explicit Admission Criteria	1 – 5 5	Staff reported that referrals stream through the RBHA to the team. The CC or another staff member meets with potential members for a screening. The team uses the *ACT Eligibility Screening Tool* developed by the RBHA to screen potential admissions. Staff said that participation with an ACT team is voluntary. If a member meets criteria and accepts ACT services, they join the team. Staff reported no administrative pressure to admit members to ACT.	
O2	Intake Rate	1 – 5 5	Over the prior six months, the peak member admission rate was two each month during April, May, and September 2019. There was one admission each month during June and August 2019, and zero admissions July 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides case management, psychiatric services, substance use treatment, and counseling. Staff reported that, on occasion, members may be referred to a brokered provider for specialty counseling.	• Ensure vocational service staff receive supervision and training so they can directly assist members to find and keep jobs in integrated work settings rather than relying on vendors. Educate all staff on the benefits of competitive employment versus

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			Staff said the ES and other staff provide employment related support (e.g., resume writing job searches) to about 15 members, but three members receive service through a brokered provider, including Work Adjustment Training (WAT). The team provides in-home services, including medication observation, and assisting members in exploring housing options. During the team meeting, staff discussed ILS services and the Housing Specialist exploring residence options with members. Staffed locations where 18 ACT members reside range from formal settings to less formal group living arrangements. Some members interviewed expressed uncertainty of available housing options or did not feel all options are offered.	other services (e.g., WAT). • Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff support. Monitor the number of members in staffed residences so that, optimally, no more than 10% reside in settings with other social service staff.
O4	Responsibility for Crisis Services	1 – 5 4	Staff reported the ACT team is available to provide crisis services 24 hours a day, seven days a week, including responding to members in the community. Some staff work weekend shifts. The CC is involved for after hour crisis calls, such as responding to a member in the community when an on-call staff needs to travel to the CBI office to obtain a company vehicle. Staff cannot transport members in their personal vehicles. Staff said they provide members with a contact list that includes the on-call and staff phone numbers. Members interviewed confirmed that the team is available after business hours. Some members interviewed voiced their concerns with communication of specific staff, and perceived unwillingness of certain specialists to provide assistance after hours. Some members said there are times staff do not answer the on-call phone, and that	• Ensure staff educates members and their supports of the team on-call availability, including staff response in the community, if needed. • Seek feedback from members to identify when staff does not answer the on-call phone. Address the issue with those staff if it is confirmed that they are not answering the on-call phone. Evaluate the team approach to providing services when members experience crisis or struggle. • On the contact sheet provided to members, consider adding a brief position description for each specialist. The contact list with position description and a smaller card with the on-call and other staff phone numbers can both be provided to members.

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			members may not call due to their belief staff will force them into the hospital. During a documented interaction, one staff assisted a member to practice calling the community Warm Line. It was not clear if the team on-call number was offered.	Providing on-call and staff phone numbers to members in alternate formats may make the information more useful to individuals in unstable or unhoused situations.
O5	Responsibility for Hospital Admissions	1 – 5 2	Staff said that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide their services when members are inpatient. Staff said that they meet with members within 24 hours of being informed of an admission, and every 72 hours thereafter. Staff reported that they text the primary covering Psychiatrist information to complete doctor-to-doctor consults with inpatient providers but cannot confirm if those contacts occur due to the Psychiatrist covering the team only two days a week. Based on information provided, the ACT team was directly involved in three of the ten most recent hospital admissions. Five members self-admitted at other CBI facilities without ACT team involvement and two members self-admitted at facilities not affiliated with CBI.	• Maintain regular contact with all members and their support networks. This may result in early identification of issues or concerns that could lead to hospitalization allowing the team to offer additional supports which may result in a reduced need for hospitalization. Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions. • Attempt to determine the reasons some members avoid using the team on-call resource. Seek feedback from members to identify when staff does not answer the on-call phone. Address the issue with those staff if it is confirmed that they are not answering the phone when on-call.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said that the ACT team was directly involved in each of the ten most recent hospital discharges. Staff from the team typically meets members at discharge to provide transportation. Staff said that when members are discharged they have follow-up appointments with a Nurse and available Psychiatrist, depending on the weekday, and staff coordinates medications with providers. Staff said that they have face-to-face contact with members for five days after a hospital discharge.	
O7	Time-unlimited Services	1 – 5	Staff reported that over the prior year, three members graduated from the team and project six	• The team should work toward maintaining an annual graduation rate of fewer than

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		4	probable graduates in the upcoming year. Staff said that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide their services when members prepare to step-down. Staff said that the process is driven by the Psychiatrist who makes the ultimate recommendation. The team reviews the member's treatment plan, progress toward goals, achievements of certain milestones, such as: managing medications, reduced hospitalization, and engagement in a meaningful activity.	five percent of the total caseload.
S1	Community-based Services	1 – 5 4	One staff reported that they spend about 75% of their time in the community and another reported spending about 33% of their time in the community. In ten member records, a median of 71% of services occurred in the community, an increase from the team's prior review. Members interviewed reported most staff meet them in the community, some reported a mix of office and community-based contacts. Some staff facilitate office-based groups.	• Continue efforts to increase the delivery of services to members in their communities. For members who prefer groups, determine if the activity can be transitioned to a community setting.
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the prior year, the team retained more than 95% of members. Staff reported that they assisted all members who moved from the geographic area to connect with new providers. Staff said that no members closed from ACT due to refusing services, not being located, or the team determining they could not be served. A *Navigator* system is in place, but no members transitioned off the team to that status in the prior 12 months, per staff report.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff provided a copy of the checklist the team uses to track eight weeks of outreach to members not engaged in treatment, or who's location is unknown. The checklist prompts for four attempts	• Monitor documented outreach and contacts with members. It may be useful to assign one staff to spot-check documentation in member records during

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			per week, two in the community. After week four of outreach, a staffing is held with the clinical lead and Psychiatrist. Staff provide for review, a formal support contacts list. During the team meeting, staff discussed outreach plans, such as checking/visiting a local park, where a specific member is known to spend time. In records, over a month time frame, there were gaps in documented outreach or contact of a week or more for two of ten members. For another member, staff documented two phone calls but no face-to-face contacts over a 15-day period. Sample calendars provided showed some comparable lapses in engagement with certain members; one contact a week with some members, but multiple contacts weekly with other members.	the team meeting to confirm recent contacts or outreach efforts are documented. This may enable the team to proactively assign staff to outreach or contact in the event of lapses.
S4	Intensity of Services	1 – 5 3	The median weekly intensity of face-to-face service time spent per member was 69 minutes based on ten member records. The average weekly service per member ranged from less than 20 minutes, to 206 minutes.	• Evaluate how the team can engage or enhance support to members who receive a lower intensity of service. The ACT team should provide members an average of two hours of face-to-face contact weekly.
S5	Frequency of Contact	1 – 5 4	The median weekly face-to-face contact for ten members was 3.25 based on records. Four of those members received four or more weekly contacts. Data provided by the agency show a higher average frequency of contact than the results of ten member record reviews over a comparable time frame. The reason for the discrepancy between agency tracking of member contacts and the results of the record review is not clear. In agency records, depending on the content of contact, staff document one or more notes based on services provided. For this review, staff and member interactions are considered one	• Increase the frequency of contact with members, preferably averaging four or more face-to-face contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact.

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			contact if the service times are chronological and show one contact.	
S6	Work with Support System	1 – 5 3	The ACT team has infrequent contact with informal (i.e., natural) supports. Staff estimates of members with informal supports ranged between 21-52%. Staff said that the team is in contact with informal supports about weekly. During the program meeting, staff discussed recent or planned contact with informal supports, for 13 members. In ten records, over the course of a month, staff documented a total of 12 contacts with informal supports, three contacts each for four members.	• The team may benefit from further training on the benefits of informal supports and 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 reported that the team serves 67 members with co-occurring diagnoses. The members are split between the two SASs. Individual treatment was discussed during the team meeting with primarily one SAS reporting on completed and planned sessions. Examples of individual treatment were found in member records. The records were similarly representative of the members with a co-occurring diagnosis on the team; information provided by staff showed six of the ten members in the sample have a substance use diagnosis. Another member with a substance use diagnosis documented in the record was not found on the list provided by staff. Based on records: two members received two sessions; two members received one session each; and, three members received no sessions, but an	• The agency approach to tracking member substance use treatment participation duration and frequency, can serve as a positive example to other providers that seek guidance on how to monitor services provided. • Staff should offer and document individual treatment to members with co-occurring diagnoses. Explore training on strategies to engage members in substance use treatment. • Work to increase the time spent in individual sessions so that the average time is 24 minutes or more across the group of members with co-occurring diagnoses. • Evaluate if SAS participation in other duties, such as medication observation, limits their ability to engage or provide individual

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			SAS documented an attempt to schedule with one of the members. One SAS documents counseling and other services in separate notes. The other SAS documents counseling, but the content of some notes seemed to blend general case management activities and treatment interventions. The program monitors member substance use treatment participation duration and frequency. The tracking showed 22 members received counseling during September 2019. The sum of the counseling shown was nearly 1500 minutes, an average of about 6 minutes weekly for members with co-occurring diagnoses.	substance use treatment. Consider shifting those duties to other staff if indicated.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff said that two co-occurring groups are available, one for members in early stages of change and a second for members in later stages of recovery. The agency monitors member's group substance use treatment participation. Tracking provided for September 2019 showed 25% of members with a co-occurring diagnosis attended a group at least once. The tracking showed a higher participation rate than what was found on group sign-in sheets for a recent month time frame, including part of September 2019. It is not clear if the agency tracking includes members who participate in other groups not identified as co-occurring focused. One staff reported about 55% of members with a substance use diagnosis attended one of the two groups over a recent month and another staff said about 30% attended. Based on sign-in sheets for the identified co-occurring treatment groups, over a recent month time frame, including part of September 2019, 7-	• 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 group. • Ensure specialists, not only the SASs, engage members to consider group treatment. • Evaluate if agency tracking includes groups in addition to the two reported co-occurring groups offered by the SASs.

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			9% of members with a substance use diagnosis attended at least once. One participant listed was not found on the team roster. Another member was not found on the list of members with a co-occurring diagnosis, so their attendance is not included in this item. Sample records showed no applicable members participated in co-occurring group treatment over the month period reviewed.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Staff said that the team is trained and uses Integrated Dual Disorders Treatment (IDDT). Training records showed that staff participated in sessions such as motivational interviewing and treatment for co-occurring disorders. Staff said that a SAS trains other specialists during weekly oversight. Staff seem to be familiar with stage of change. Staff did not appear to be familiar with the term *stage wise* treatment, but identified interventions related to specific stages of change. Staff discussed members' stages of change during the meeting observed and discussed nuanced differences in some instances. Staff gave examples of recent harm reduction efforts. Based on records, treatment plans address substance use, groups and/or individual SAS service. Staff said that the team does not directly refer to Alcoholics Anonymous (AA) or similar groups but will assist members in accessing those supports if requested. Staff can accompany members. Staff said that the team occasionally refers members for medical withdrawal management. One staff said that detox may be needed if a member was intoxicated due to alcohol use. Not all applicable staff interviewed seemed familiar with other substances likely to require medical withdrawal management. It does not appear all staff use	• Implementing a comprehensive co-occurring model may help the team to maintain consistent service if SASs transition off the team and ensure staff draw from the same treatment resources. • If it has not occurred, the two CBI staff supervisors of the SASs should consider coordinating what topics are covered so that consistent evidence-based co-occurring treatment information is provided. SASs may then be better equipped to cross-train other staff on the team in the adopted co-occurring model. • Consider reviewing with staff techniques to introduce recovery language into conversation with members and support systems. Consider monitoring documentation for recovery language. • Staff may benefit from training on strategies to engage members in individual and group substance use treatment.

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			recovery language in documentation. One staff documented that a member was “staying clean”. Staff said that prior covering Psychiatrists used medication-assisted treatment (MAT) but could not confirm any members receive that support currently. Staff provided multiple treatment resources utilized. Although there may be beneficial elements of each resource, more comprehensive approaches are available for individuals with co-occurring diagnoses.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team is staffed with one or more individuals with personal lived experience of psychiatric recovery. Interviewees, including some members, said there is a staff member on the team with lived experience who shares aspects of their story, when appropriate.	
Total Score:		**3.68**		

ACT FIDELITY SCALE SCORE SHEET

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

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	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
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	**3.68**	
Highest Possible Score	**5**	