ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: June 1, 2022

To: Eric Rathburn, Clinical Coordinator
John Hogeboom, President/CEO

From: Vanessa Gonzalez, BA
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AHCCCS Fidelity Reviewers

Method

On March 29 - 31, 2022, Vanessa Gonzalez and Annette Robertson completed a review of the Community Bridges Incorporated (CBI) Avondale 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.

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.

The Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Review tool does not accommodate delivery of telehealth services. Delivery of telehealth services, including phone only, were calculated for this review, however those totals are not included in calculating scores for those items that measure in-person contact between the ACT team and members, except for prescribers, due to the shortage in Arizona. This review was conducted remotely, using videoconferencing or telephone to interview staff and members.

The individuals served through the agency are referred to as "clients", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

During the fidelity review, reviewers participated in the following activities.

- Remote observation of an ACT team program meeting on March 29, 2022.
- Individual interview with the Clinical Coordinator (CC).
- Individual interviews with the Psychiatric Nurse Practitioner, and the Substance Abuse, Housing, and the Rehabilitation Specialists.
- Individual phone interviews with two members participating in ACT services with the team.

- Charts were reviewed for 10 randomly selected members using the agency's electronic health records system.
- Review of documents: Mercy Care ACT Admission Criteria; *ACT Contact Information; F-ACT Re-Engagement Policy; F-ACT and ACT No show follow up;* resumes and training records for Substance Abuse Specialist (SAS) and Vocational Specialists (VS) staff.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the 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 review. 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 demonstrates and implements knowledge of Integrated Dual Diagnosis Treatment, including the Stage Wise Approach and harm reduction.
- The team Prescriber excels at providing 24/7 support to the team and taking on additional job tasks while the Nurse positions (2) are vacant. The Prescriber is highly involved in member care, provides support and education to the team, and meets with members in the community as well as conducts jail visits.
- The team had a very high retention rate of members, 95%.
- When members discharge from inpatient psychiatric settings, the team is highly involved in aftercare.

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

- Increase continuity and staff capacity. The ACT team should fill vacant positions, especially the vacant Nurse positions to relieve some of the workload from the Prescriber. Filling vacant positions as soon as possible helps to reduce burden on team staff and ensures members do not experience a disruption in service due to a lack of staff.
- Work to provide more frequent and intensive individualized services to members, with a focus on delivering those services in the community.
- Increase efforts to engage individuals with a co-occurring diagnosis to participate in substance use treatment groups provided by ACT staff.
- The ACT team should improve efforts to connect with member's natural supports, a valuable resource to both members and the team. Ensure these efforts are documented in member records. Consider including discussion during the program meeting.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review there were six full-time equivalent (FTE) staff on the team, excluding the prescriber. The team services 98 members resulting in a 16:1 member to staff ratio.	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 – 5 4	Staff estimated 80% of members are seen by more than one staff in a two-week period. The team developed a rotating roster system that is arranged by zip codes. Staff are assigned a different region daily to ensure members are provided a range of staff expertise and personalities. In addition, staff are scheduled on Saturdays and Sundays to ensure members needs are met. Of ten randomly selected member records reviewed for a month period, a median of 70% received in-person contact from more than one member of the team in a two-week period. Staff report that neither SAS are included in the rotation.	• Increase in-person contact of diverse staff with members. Team staff are jointly responsible for making sure each member receives the services needed to support recovery. Consider including all direct services staff in the rotation when there are multiple staff vacancies. Ideally, 90% of ACT members should have contact with one than one staff in a two-week period.
H3	Program Meeting	1 – 5 5	All staff interviewed reported that the team meets daily to review all members on the team roster. Staff are expected to attend on days they are scheduled to work. The team offers a hybrid team meeting allowing staff to join in-person or through videoconferencing when out in the community delivering services or when working from home. During the meeting observed, both the ACT Fidelity Specialist and the SMI Administrator for F-ACT and ACT were present and are reportedly normally in attendance. The CC provided direction and assigned responsibilities to staff to follow up on member needs. The prescriber, who attends all five days, provided insight and updates on members seen, as	

			well as identifying additional needs for the team to address with members.	
H4	Practicing ACT Leader	1 – 5 3	The CC estimates spending 25% of the time delivering in-person services to members of the team. During the program meeting observed, reports were made of the CC having contact with members, plans to conduct home visits for several members, as well as plans for medication observation. Of the ten member records reviewed, four members had in-person services delivered by the CC documented, in addition to one phone call with a member providing medication support. The CC appears to play a large role in providing coordination of care when members are engaged with other providers or when there are legal guardians involved. A productivity report provided showed 19% of service delivery was in-person. *The fidelity tool does not accommodate delivery of telehealth services.*	• Optimally, the CC should provide in-person services to members 50% or more of the time. ACT leaders that have direct clinical contact with members are better able to model appropriate clinical interventions and remain in touch with the members served by the team. Shadowing and mentoring specialists delivering community-based services, such as assertive outreach, home visits, and skill building activities designed to promote integration and recovery qualify providing direct service. • Explore potential barriers to the CC providing direct services to members. Consider identifying responsibilities that could be transferred to administrative staff or other team members.
H5	Continuity of Staffing	1 – 5 2	Based on information provided, the team experienced turnover of 71% during the past two years. There were 17 staff that left the team during the period reviewed. Data provided showed the positions with the highest turnover were the Rehabilitation Specialist (RS), Housing Specialist (HS), and Independent Living Skills Specialist (ILS) with three transitions per position over the last two years. Members interviewed expressed concern for the high turnover rate, indicating that requests for services can be slow due to the staffing rate.	• ACT teams should strive for a turnover rate of less than 20%. Maintaining consistent staffing supports team cohesion and the supportive relationship between members and staff. • Continue hiring efforts for vacant positions to reduce caseload burden for staff and ensure the ACT team has critical positions filled to better member experience. When considering staff/position responsibility for on-call rotation, consider vacancies of the team. Although some positions may not normally be included in rotation, during times of low staffing, temporarily including specialist positions would be appropriate to

				help reduce potential burden on ACT team staff.
H6	Staff Capacity	1 – 5 3	Review of data provided shows there have been 40 vacant positions during the past 12 months, resulting in a 72% staffing capacity for the team. The Peer Support Specialist (PSS) position was vacant for 12 months, a Nurse position for 11 months, the ILS position for seven months, and the ACT Specialist (AS) position for six months.	• To ensure adequate coverage, staff diversity, and continuity of care for members, fill vacant positions with qualified staff as quickly as possible with a goal of 95% full staffing annually. Filling vacant positions quickly also helps to reduce potential burden on current staff.
H7	Psychiatrist on Team	1 – 5 5	The Prescriber spends one day in the community a week visiting members that have difficulty attending appointments at the clinic, as well as conducting jail visits. The Prescriber is available 24-hours, seven days a week to ACT staff. Staff reported the Prescriber is easy to access to coordinate member care and attends the program meeting daily. Records reviewed showed the Prescriber was active with six out of ten members which included four visits in the community and two visits in the office in the month period reviewed. The Prescriber's role includes assessing members, diagnosing, medication management, drawing labs, coordinating care with primary care physicians, providing housing resources, case management, and tracking down members that have lost contact with the team. Staff interviews indicate the Prescriber does not have any other responsibilities outside of their ACT team.	
H8	Nurse on Team	1 – 5 1	The ACT team currently has no Nursing staff on the team and the Prescriber was covering those duties at the time of the review. The Prescriber reported that around 5% of their time is spent on nursing related tasks.	• Fill the vacant Nurse position. The team should have 2 FTE ACT Nurses. When screening potential candidates for the position, consider experience working with members with a co-occurring disorder.
H9	Substance Abuse Specialist on Team	1 – 5	There are two Substance Abuse Specialists (SAS) assigned to the team. Both SAS have master's	

		5	degrees and relevant experience according to resumes provided. Both SASs joined the team in the Fall of 2020. Reviewers were only provided one recent training the SASs had complete, although trainings did date back to 2020. The most recent course taken was on the delivery of group therapy. One SAS is continuing their education in Trauma Informed Care.	
H10	Vocational Specialist on Team	1 – 5 4	The team has two Vocational Services staff, an Employment Specialist (ES) that has been in the role since 2017, and an RS that started one year ago. Training records provided showed the RS completed disability benefits and employment as rehabilitation trainings upon being hired a year ago, but nothing more related to supporting members to seek and find employment in integrated settings. There were no current training records provided for the ES.	• Ensure that both vocational staff, regardless of experience, receive ongoing training and supervision in assisting people diagnosed with serious mental illness/co-occurring diagnoses to find and retain competitive employment. Training should include techniques to engage members to consider employment; job development strategies; the importance of supporting in-person employer contact soon after members express an employment goal; and the provision of follow-along supports to employed members. • If not done so already, consider supporting VS staff to attend the quarterly vocational meetings available through the Regional Behavioral Health Authority to keep up to date on resources available.
H11	Program Size	1 – 5 3	At the time of the review, the team had seven staff to provide direct services to members of the team. Four positions were vacant at the time of the review, two Nurse positions, the ILS, and PSS. Member interviews indicated concern about the low number of staff, and that it can lead to a slower response by staff for member requests.	• The ACT team should have at least 10 staff to ensure members are provided with all the services they require in a timely matter. In addition, this will help prevent potential staff burn out by lightening workloads.
O1	Explicit Admission Criteria	1 – 5	Staff reported receiving referrals from other provider network organizations, other ACT teams, hospitals,	

		5	supportive and connective level of care case management teams, and occasionally from the Regional Behavioral Health Authority (RBHA) for persons with high acuity before they are determined to have an SMI diagnosis. Based on interviews with staff and documents provided, the team has clear admission criteria, following the procedures outlined by the RBHA. Referrals will come from other ACT teams and connective and supportive teams for a step-up in member level of care. When inpatient teams refer, coordination occurs with the social worker and a doctor-to-doctor meeting is conducted. Family members are also encouraged to participate in the process. Together the CC and the prescriber decide if referrals are appropriate for ACT. When a referee declines the offer of ACT services, the CC will enlist a CC from another agency ACT team to reach out to the member to provide a different experience and extend the final offer to enroll. The team denies pressure from outside sources to admit members to the team.	
O2	Intake Rate	1 – 5 5	The team had an appropriate intake rate over the six months before the fidelity review. Although the team had four vacant staff positions during the month of March 2022, two admissions did occur. For the months of October, November, December, and February, there were no admissions. There was one new admit in January.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team is directly providing counseling/psychotherapy to at least 15 members. The team provides most members with psychiatric services. One member receives psychiatric services off the team and the team reports to having	• Reduce the dependence of substance use treatment services off the team. ACT members are not normally successful with traditional case management, thus the importance of providing all treatment

			discussions with the member related to moving those services to the team. The team does provide most of the employment and rehabilitative services to members, 10 of which are actively employed in an integrated work setting. However, the use of work adjustment programs duplicates ACT services, three members are enrolled in sheltered work programming. Related to housing, more than ten percent of the members on the team live in a setting where there is a duplication of ACT services. Staff interviewed reported referring to member treatment plan goals and supporting steps toward building independence which may include basic cleaning and organizing skill development, as well as maintaining healthy relationships with neighbors. Of the 68 members with a co-occurring disorder diagnosis, 25 are engaged with the team for individual substance use disorder counseling. However, five members are receiving substance use treatment services outside of the ACT team. And although one of those five is receiving those services within the agency, it is not with the ACT team.	needs within the unit of the team provides the continuity and individualized care that supports members in their recovery. Additionally, retaining treatment services within the team ensures members are receiving care that is framed in a co-occurring model. • System stakeholders and agency leadership may not be in the position to move the pendulum on increasing access to affordable independent housing for ACT members given the current housing shortage in the metropolitan area. However, before referring members to staffed housing, consider providing those members with the support to apply to low-income housing programs, explore employment to increase income thereby providing a larger pool of housing options available, and support members in applying to eligible benefits to reduce rent burden.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour 7 days a week crisis response to members of the team. Members are provided the *ACT Contact Information* sheet with positions and associated phone numbers listed as well as the on-call number, noting that it does not accept text messages. Members are encouraged to contact the team when in crisis, however, occasionally the local crisis response team is called first. Staff report being contacted by local crisis responders and being forwarded the call when this	

			occurs. When members require an on-site response, staff consult and update the ACT CC as the intervention progresses. At the time of the review the team had four staff providing on-call coverage as the SAS positions are not included in rotation responsibilities.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff interviewed reported that ideally the team would engage with all members when experiencing an increase in symptoms that may require inpatient care, triage needs, and fully participate in the psychiatric admission process. When the member is in the community, staff will assess the member's needs, coordinate with the team lead and prescriber for next steps, and if needed, connect the member to the prescriber through a telehealth triage appointment, or transport the member to the clinic for assessment. The team supports members in identifying the inpatient setting of their choice and will accompany them to the unit, staying until admitted, and providing inpatient staff with the most recent treatment records. Of the ten most recent member psychiatric hospital admissions, the team was directly involved in 40%. Review with staff of the admissions the team was not involved, nearly all were members that admitted without contacting the team for support. For one member, family did reach out to the team, but staff did not meet with the family nor the member in the community to offer support. The member's family facilitated the admission, although staff did contact the facility to inform of the member's intent to self-admit.	• The team should identify and seek solutions to barriers to direct team involvement in member inpatient admissions. This may include members' reasons for not utilizing the 24/7 on-call service available, the impact of staff turnover on the therapeutic alliance, and the building and engagement of member's natural supports. Optimally, the team would be involved in 95% of member psychiatric admissions. • For members that repeatedly admit without ACT team involvement, consider discussing their individual needs and developing plans for the team to support those members when seeking inpatient care. • Increase contacts with members and their supports. Earlier intervention to address member needs may allow the team opportunity to offer interventions and resources, as well as assist when seeking inpatient care. • When member's natural supports reach out to the team, provide onsite support and assistance from the team. Utilize the team's expertise in supporting members when experiencing a psychiatric emergency

				as an opportunity to build and maintain trusting relationships with members and their supports. Additionally, it is an opportunity to model appropriate language and response to members' mental health crises.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff report that discharge planning begins at the point of admission to a psychiatric unit. Within the first 24-hours, the team schedules a staffing with the inpatient team and the team explores what transpired that caused the admission. Most hospitals continue to deny staff visits, but when available, staff will schedule to see members. The Prescriber schedules coordination with treating Psychiatrists and the team continues to engage in staffings with the inpatient team to identify member needs. Upon discharge, the team will assist the member in getting new medications, secure food, and other needs, as well as schedule the member with the Prescriber and primary care physician. The team follows a five-day follow up protocol which entails consecutive in-person, phone, or telehealth visits. The team prefers in-person visits; however, some members may have housemates/family with medical conditions that require limiting risk of exposure to illnesses, thus prefer virtual or phone check-ins. Upon review with staff, of the ten most recent psychiatric discharges, the team was directly involved in 100% of those discharges.	
O7	Time-unlimited Services	1 – 5 4	The team graduated three members in the 12 months leading up to the review. Staff reported five members are currently in the process of stepping down to a lower level of care (graduating from ACT).	• The team should work toward maintaining an annual graduation rate of fewer than 5% percent of the total caseload. ACT teams traditionally serve those with the most

			These members are in various stages in the process with a reduction in services from the team, transfer clinics identified, and transfer packets sent. It was estimated that an additional ten members are expected to graduate within the next 12 months.	complex behavioral health issues and have been unsuccessful in traditional outpatient teams.
S1	Community-based Services	1 – 5 4	Staff interviewed reported 50% of in-person contacts with members occur in the community. However, the results of ten randomly selected member records reviewed show staff provided services a median of 63% of the time in the community. Both members interviewed stated seeing staff at the clinic/office more often than in the community. One member interviewed reported living in a group home and that no one from the team has come to assess the conditions. Additionally, a member interviewed expressed frustration because they were expecting staff to accompany them to a medical appointment, however, the team did not communicate to the member staff would not be in attendance as planned.	• Contacts with members in natural settings are more effective than in an office or clinical setting. Work as a team to spend 80% or more of contacts with members in the community.
S2	No Drop-out Policy	1 – 5 5	According to the data provided, the ACT team had no members that were closed because of refusing services, three could not be located, one could not be served, and one left the area without a referral from the team. A total of 5% dropped out of the program during the past year.	
S3	Assertive Engagement Mechanisms	1 – 5 4	One staff interviewed reported the team recognizes that outreach efforts for dis-engaged members are most successful in the beginning, when members first lose contact with the team. As soon as members are moved to the outreach list, the team is intensive, using multiple approaches every day. Additionally, more than one staff may conduct outreach on any given day as observed during the program meeting.	• Consider monitoring documented outreach and contacts with members. It may be useful to assign one staff to spot-check documentation in member records during the team meeting to confirm recent contacts or outreach efforts are entered. This may enable the team to proactively

			Reviewers were provided the *F-ACT Re-Engagement Policy* which paralleled reports by staff. Records reviewed, however, did not contain the documentation of the full implementation of the *F-ACT Re-Engagement Policy* by the team. One record reviewed was an incarcerated member and no outreach documentation was noted in the records for over a month.	assign staff to outreach in the event of lapses.
S4	Intensity of Services	1 – 5 2	Per review of ten randomly selected member records for a month period before the fidelity review, the median amount of time the team spends in-person with members per week, is 21.38 minutes. Five of the ten member records reviewed averaged less than 10 minutes of in-person contact by the team each week. Both members interviewed expressed a low level of intensity of services being delivered by the team.	• Members should be provided an average of two hours a week or more of in-person contact to help with serious symptoms and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on their individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 - 5 2	Of the ten records randomly sampled, ACT staff provided an average frequency of 1.13 contacts to members per week. The record with the highest averaged 11.75 contacts per week as the member was receiving twice daily medication support from the team. This records also logged the highest intensity of all records reviewed. One member was incarcerated during the time of the review. Median phone contact by the team to members was one contact in a month period. Seven of the ten member records reviewed had contact by phone from the team documented. *The fidelity tool does not accommodate delivery of telehealth services.*	• The team should continue efforts to contact members in as safe a manner as possible, as community health conditions allow. Optimally, ACT members receive an average of four or more in-person contacts a week. The number of contacts may vary, with some members receiving fewer and others receiving more contact depending on immediate and emerging needs.
S6	Work with Support System	1 - 5	During the meeting observed, staff identified natural supports for at least 35 members. Staff	• ACT teams should have four or more contacts per month for each member with a

		2	interviewed varied in their estimates of members with natural supports from 40 - 98%. However, per the ten member records reviewed, only three included documentation of staff contacting natural supports for an average of .8% contacts. Staff reported natural supports consisted of guardians, parents, siblings, and spouses. Members interviewed reported minimal contact between the ACT team and member's natural supports. One member indicated their natural support often must reach out to the ACT team for information. Staff reported no services are provided for natural supports.	support system in the community. Developing and maintain community support further enhances members' integration and functioning. As much as possible, contacts with natural supports should occur during the natural course of providing services to members. • Continue efforts to engage members' natural support systems as key contributors to the member's recovery team. Staff should model recovery language and provide tips to family members and other natural supports how they can support member care.
S7	Individualized Substance Abuse Treatment	1 – 5 4	There are 68 members on the team that were identified as having a substance use disorder diagnosis. It was reported that of the two SAS, one has 42 assigned to their caseload and the other SAS has the other 26. Staff interviewed indicated normally meeting with 10 members a week for around 50 minutes. Records reviewed showed sessions occurred between 5 - 70 minutes. Most of the contacts were provided by phone, but in-person contacts were taking place largely in the community rather than the office. The SAS provided detailed notes regarding member's progress in recovery. Of the records reviewed, two of the four members with co-occurring disorder (COD) diagnosis were seen by an ACT SAS during the month period reviewed.	• Continue efforts to engage members with a co-occurring diagnosis with substance use disorder treatment services. Work to increase the time spent in individual sessions and increase the number of members engaged so that the average time is 24 minutes or more per week across the group of members with co-occurring diagnoses.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team offers one substance use treatment group weekly to members with a COD assigned to the team and is targeted for members in the pre-contemplative/contemplative stages of recovery. The SAS facilitates the group with the CBI 99th Avenue ACT team which shares the office building.	• All ACT staff should 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.

			Staff reported six unique members attend each weekly group. Review of sign in sheets for a recent month period provided to reviewers showed 13 unique individuals with a COD attended at least one substance use treatment group. One to two members attend the group virtually through videoconference.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 5	ACT staff interviewed were knowledgeable with the stage-wise approach to substance use treatment and members' stages of change were identified in the morning meeting observed. The person-centered team emphasizes harm reduction as their focus and an individualized approach for all members, rather than expecting abstinence. However, if a member identifies abstinence as their goal, the team will support them. The team does not encourage participation in peer run 12-step programs or detox unless a member has indicated that is something they want. Staff report using motivational interviewing to support clients in identifying individualized goals. Treatment plans reviewed for members with a COD were written in the member point of view and identified services the team would offer and provide to support steps toward recovery. Language utilized in documentation was accepting of member goals and did not appear to use confrontation as a tactic, rather, staff supported members to identify goals and next steps.	• Continue to provide all ACT specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Dual Disorders Treatment, in the principles of a stage-wise approach to interventions, harm reduction, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new or less experienced staff. Identifying a co-occurring disorder model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in their recovery.
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff and member interviews indicated there are staff with lived psychiatric recovery on the team and when appropriate, will share their story of recovery with members. Staff with lived psychiatric recovery that	

			were interviewed, reported sharing the same level of responsibilities as other ACT staff.	
Total Score:		**105**		

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	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	1
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	4
11. Program Size	1-5	3
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	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	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	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	5
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.75**	
Highest Possible Score	**5**	