ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with Western Interstate Commission for Higher Education Behavioral Health Program to conduct Fidelity Reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an evidence-based practice (EBP).

Method

On April 11 – 12, 2023, Fidelity Reviewers completed a review of the Community Bridges, Inc. Forensic-ACT 1 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. operates several locations throughout Arizona. Services provided include supportive housing, crisis stabilization, ACT, and integrated healthcare. The agency operates three Forensic ACT teams and three ACT teams in the Central Region of Arizona. 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.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to interview staff and members.

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

- Remote observation of the ACT team program meeting on April 11, 2023.
- Individual video conference interview with the Clinical Coordinator (CC).

- Individual video conference interviews with Co-Occurring, Employment, Rehabilitation, and Peer Support Specialists for the team.
- Individual phone interviews with three members, and one guardian, participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *F-ACT Re-engagement Policy*, *Mercy Care FACT Admission Criteria*; cover pages for substance use materials referenced for individual and group co-occurring disorder treatment including *Motivational Interviewing, Helping People Change, W. Miller and S. Rollnick*, and resumes and training records for Vocational and Co-Occurring Specialist 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 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 included as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team maintains a low member to staff ratio, 9:1, allowing members the opportunity to have individualized service delivery.
- The team encourages development of stable, ongoing relationships with members by maintaining a low graduation rate.
- The majority of services members receive are community based, allowing staff to assess needs in members' natural environments.
- Members are engaged and outreached assertively for services. Members do not endure long periods between contacts by ACT staff.

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

- During the past 12 months, the team experienced a high rate of position vacancies, potentially reducing services to members and increasing burden by staff on the team. Explore opportunities to reduce position vacancies.
- Frequency and intensity of services delivered to members was low. Provide members frequent and in-person contacts that align with goals identified on service plans. Ensure all services delivered, in-person, by phone, collateral, are documented in member records.
- It is unclear how many or how often Natural Supports are involved in member care. Continue to work with members to build a natural support system. For those with Natural Supports, continue working to build collaborative relationships for the benefit of the member and the team.
- There is limited involvement by members in individual and co-occurring group treatment provided by the team. The entire ACT team is responsible for engaging members, as appropriate given their stage of change, to participate in some level of substance use treatment services.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team serves 67 members with eight full-time equivalent (FTE) direct service staff, excluding the Psychiatrist. The team has an appropriate member to staff ratio of approximately 9:1. Staff on the team include the CC, Nurse, Co-Occurring Specialist, Employment Specialist, Rehabilitation Specialist, Peer Support Specialist, ACT Specialist, and Housing Specialist.	
H2	Team Approach	1 – 5 3	Staff interviewed reported that each specialist is assigned approximately ten members. Staff are expected to meet with those members in the community weekly for a total of four contacts a week. Staff reported aiming for one to two in-person contacts and two phone contacts a week. Specialist staff schedules are staggered four ten-hour days, including weekend coverage. The use of a weekly rotating zone approach to meeting members in the community was identified as currently being utilized. The Co-Occurring Specialist does not participate in the rotation. The team also uses a group chat to stay updated on member needs. Of ten randomly selected member records reviewed for a month period, a median of 40% received in-person contact from more than one FACT 1 staff in two weeks.	• Ideally, 90% of ACT members have contact with more than one staff in a two-week period. • Consider eliminating member assignments. The team approach ensures continuity of care for members and creates a supportive environment for staff, potentially reducing the burden of responsibility. Staff should be cross trained to work as a transdisciplinary team rather than individual case managers. ACT staff should collaborate on assessments, treatment planning, and day-to-day interventions.
H3	Program Meeting	1 – 5 4	The team meets in-person utilizing a video conference platform to share member calendars and to be able to include staff that may be in the community. The team meets five days a week to	• ACT teams use the program meeting to focus on member needs and concerns, solve problems, and engage in person-centered planning and recovery-oriented

			discuss all members assigned to the team. Staff work staggered days and are expected to attend on days scheduled to work. The Psychiatrist typically attends the meeting three times a week. During the meeting observed, the Co-Occurring Specialist ran the meeting. Most comments by staff related to upcoming or overdue paperwork. Directives offered by the CC to staff focused on outreach activities and overdue administrative paperwork assignments. An agency leadership staff attended the meeting that normally is not present.	rehabilitation efforts rather than the completion of administrative tasks. • Support the CC in running the FACT 1 program meeting. ACT CC's use the program meeting to lead discussion and planning to address member needs.
H4	Practicing ACT Leader	1 – 5 2	The CC reported having direct contact with members up to five times a week, or approximately 5% of what is expected of other specialists on the team. One member record reviewed included documentation of the CC attending an inpatient staffing along with the member and treatment team.	• Increase in-person member contact. Optimally, the ACT CC delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff.
H5	Continuity of Staffing	1 – 5 3	Based on the information provided, the team experienced a turnover of 58% during the past two years. Fourteen staff left the team. Positions that experienced high turnover include the CC and Co-Occurring Specialist.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.
H6	Staff Capacity	1 – 5 2	The team had 61 vacancies in the past 12 months, operating at 58% of full staffing capacity. Positions with the highest turnover included Vocational Specialist staff and the second Nurse position.	• Continue efforts to retain qualified staff with the goal of operating at 95%, or more, of full staffing annually. • In an effort to support retention, ensure staff receive training and supervision for their specialty. Research shows staff remain in positions longer when supported in their roles by being provided supervision and training in their specialty practice.

H7	Psychiatrist on Team	1 – 5 3	The team has a 50% FTE Psychiatrist. The assigned Psychiatrist is also assigned to another FACT team at the time of the review. Staff were unclear on the Psychiatrist's schedule, but reported members are scheduled five days a week. The Psychiatrist is accessible to the team by a messaging application, email, or text. Staff provided contradictory information relating to whether services are delivered in-person or via telehealth. Seven of the ten member records had a phone session with the Psychiatrist documented. Members are generally scheduled every 30 days, as evidenced in records. Some members are seen more frequently due to follow-up care provided after inpatient psychiatric hospitalization. The Psychiatrist is unavailable to the team after hours or on weekends but participates in the agency on-call rotation. When the team requires guidance after hours or weekends, staff contact the on-call medical provider, rather than medical personnel assigned to members of the team.	• Increase availability of the Psychiatrist to match client roster needs. Ideally, one FTE Psychiatrist per 100 members. • ACT psychiatrists serve as medical directors for the team. In addition to medication monitoring, the psychiatrist functions as a fully integrated team member, participating in treatment planning and rehabilitation efforts, meeting with members in the community, and being available to team staff after hours and weekends.
H8	Nurse on Team	1 – 5 4	The team has one Nurse that has been with the team for many years. The Nurse works four ten-hour days delivering services to members in the office and the community. Responsibilities include coordinating member care with inpatient, primary, and specialty providers, and providing direct care to members of the team. The Nurse is readily available to the team on days scheduled to work. The Nurse is not available after hours or weekends. The team utilizes agency staff when the Nurse is not scheduled to work.	• Ensure appropriate ACT team coverage of 100% dedicated, two full-time nurses per 100 members.
H9	Co-Occurring Specialist on Team	1 – 5	The team Co-Occurring Specialist (COS) is a recently Licensed Associate Substance Abuse	• Optimally, ACT teams are staffed with two Co-Occurring Specialists for a roster of 100

		4	Counselor with a Master of Science in Addiction Counseling. Recent training completed in integrated co-occurring disorder treatment, substance use, and co-occurring disorders was identified in the documentation provided. The COS attends monthly group supervision with a Licensed Professional Counselor.	members, each with a year or more of training/experience providing substance use treatment services. • Provide annual training to Co-Occurring Specialists in co-occurring treatment best practices, including appropriate interventions, i.e., stage wise approach, based on members' stage of change. Co-Occurring Specialists should have the capability to cross-train other staff on the team, providing guidance on appropriate interventions based on members' stages of treatment and in the adopted co-occurring model utilized by the team.
H10	Vocational Specialist on Team	1 – 5 4	The team has two Vocational staff. The Employment Specialist has recent training in vocational and rehabilitation services and disability benefits along with more than one year of experience supporting individuals finding employment. The Rehabilitation Specialist has recent training in employment and rehabilitation services but has less than one year experience supporting persons in finding employment.	• Ensure both vocational staff continue to receive ongoing training in helping members find and retain competitive employment in integrated settings. Ongoing supervision should be provided to support skill development during this first year in the role. • If not done so already, support Vocational Specialist staff to attend quarterly vocational meetings available through the Regional Behavioral Health Authority to keep current on available resources.
H11	Program Size	1 – 5 4	At the time of the review, the team had 8.5 FTE staff on the team, including the Psychiatrist. Three direct service positions were vacant: the second Nursing position, the second Co-Occurring Specialist, and the Independent Living Skills Specialist.	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, a minimum of 10 direct service staff, allows the team to consistently provide diverse coverage; helps to prevent potential staff burn-out; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the

			This item does not adjust for the size of the client/member roster.	delivery of comprehensive, individualized service to each member.
O1	Explicit Admission Criteria	1 – 5 5	The team follows the *Mercy Care FACT Admission Criteria*. Several staff are trained to complete screenings of new referrals, supporting a team process. The CC and Psychiatrist have the final decision on admissions to the team.	
O2	Intake Rate	1 – 5 5	During the past six months the team had six – seven admissions. All admissions occurred during February and March. The team has an appropriate rate of admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides all psychiatric services and medication monitoring except for one member receiving those services from the inpatient substance use provider in which they are currently participating. At least three members are receiving counseling/psychotherapy and another three members are engaged in substance use treatment services with the team. In addition, the team stated several members are working and receive support from the team in retaining work. The team also supports members after release from incarceration to prepare to work by getting necessary documents needed for employment, assist with resume writing, mock interviewing, and locating clothing resources. Many of these members require support in living skills as they transition back into society. No members on the team are engaged in employment services off the team. The team is working to support members in finding affordable housing, even when that results in temporary settings with the ultimate goal of	• Continue to monitor the number of members in staffed residences. As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all services and support from the team.

			long-term housing solutions. At the time of the review, at least 13 members were residing in housing that duplicated ACT services available.	
O4	Responsibility for Crisis Services	1 – 5 5	Reviewers were provided a copy of the document offered to members that lists most FACT 1 staff, roles, phone numbers, and the 24-hour team on-call number. On-call responsibility is rotated weekly among all team specialists. Staff reported that the team answers members' calls to the on-call number 24 hours of the day, providing support by phone, and when needed, will meet with members in the community. When specialists require further direction while responding to members by phone, staff contact the rotating on-call supervisor for direction, which may or may not be the CC assigned to FACT 1. All members interviewed reported awareness of the on-call number and 24-hour services available from the team.	
O5	Responsibility for Hospital Admissions	1 - 5 3	Staff reported that when a member is showing an increase in symptoms, staff will offer inpatient care and transport the member to a facility, waiting with them until admission. Staff reported assessing safety as a priority for the member and the team, but that members are not triaged by the Nurse or Psychiatrist. When a member is not amenable to inpatient care, a team of two will meet with the member in the community to assess and potentially petition for involuntary psychiatric treatment. Staff encourage members to inform inpatient staff of their connection to the FACT 1 team if they are admitted without the assistance of the team. During the program meeting observed, the team described efforts to support a	• Increase the team participation in supporting members requiring psychiatric hospitalization to 95%. • Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build a rapport with natural supports. • Work with each member and their support network to discuss how the team can support members in the event of a

			member's psychiatric admission through the process of amending the court ordered treatment. Per the review of the ten most recent psychiatric hospital admissions, the team was directly involved in 50%. These admissions occurred over a two-month period, December to February. Five members admitted themselves to inpatient psychiatric care facilities without the assistance of the team.	psychiatric hospital admission. Proactively develop plans with members on how the team can provide aid during admission, especially for members with a history of seeking hospitalization without team support.
O6	Responsibility for Hospital Discharge Planning	1 – 5 3	Staff interviewed provided differing responses relating to assignment of coordination of care responsibilities from the team with inpatient teams. Staff reported contact is supposed to be made within 24 hours of admission to begin the discharge planning process but is not consistently done. Staff report hospitals are not limiting team access to members. A meeting is arranged with the inpatient team, including natural supports and guardians, to discuss progress and discharge plans. Upon discharge, the team obtains paperwork from the inpatient team, transports the member to their residence or planned placement, staying through the intake process. Members meet with the Psychiatrist on the day of discharge or within 24 hours. The team conducts a five day follow up, ideally in-person but can be completed by phone, to assess behaviors, medication adherence, and to discuss new goals. Staff indicated not all discharge activities are documented in member records. Per review of data for the last ten psychiatric hospital discharges with staff, the team was directly involved in 70%. These discharges occurred over a three-month period, January to	• The ACT team and system partners should collaborate to resolve barriers to the ACT team being directly involved in 95% or more of psychiatric discharges. • Coordinate with inpatient staff, members, and their supports (both natural and formal) to reinforce the benefits of including the team in hospital discharges. • Track member discharge coordination, including visits to members that are inpatient. This may prevent lapses of coordination with the treatment team which may result in earlier identification of issues or concerns relating to members, allowing the team an opportunity to offer additional supports.

			March. Member records reviewed showed one member experiencing multiple facility placements, including hospitalization, and lacked evidence of in-person contact by the team for the month period reviewed. During the program meeting observed, the team described a plan to engage a member at their home the same day that the member had left the facility against medical advice.	
O7	Time-unlimited Services	1 – 5 5	Data provided shows that the team graduated one member in the past 12 months. Staff interviewed stated that there are potentially three members on target for graduating in the next year.	
S1	Community-based Services	1 – 5 4	Staff interviewed reported that most in-person services, 70 - 85%, occur in the community. One staff stated that some members decline meeting at the clinic. Occasionally restricted access to agency vehicles impacts community service delivery especially when staff need to transport members as using an agency vehicle is required. The results of ten randomly selected member records reviewed show staff provided services a median of 67% of the time in the community.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities, where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1 – 5 4	According to data provided and reviewed with staff, the team had ten members drop out of the program in the past year for a retention rate of 87%. Four members were unable to be located, another five were closed due to long term incarceration, and one member declined to engage in services with the team.	• ACT teams ideally retain 95% of the entire caseload yearly. Work to retain membership in ACT. Several factors can impact this number positively including clear admission policies, consistency in staffing, natural support involvement, assertive engagement practices, and taking a recovery perspective with member care.

S3	Assertive Engagement Mechanisms	1 – 5 5	The team provided the *F-ACT Re-Engagement Policy* to reviewers. During the program meeting observed, at least five members were identified as being on outreach with the team. Staff identified outreach activities planned such as contacting the county sheriff's department for possible incarceration or searching for members in frequented locations. A review of member records showed that staff consistently reach out to members by phone and in person after missing scheduled appointments or when it has been several days since the last contact. One staff stated that the team makes four attempts each week and continues efforts regardless of response, not giving up on the member. Often, when members are on outreach, they will show up at the clinic and want to re-engage in services.	
S4	Intensity of Services	1 – 5 1	Per a review of ten randomly selected member records, during a month period before the fidelity review, the median amount of time the team spends in-person with members per week, is 12.38 minutes. The highest weekly average was 112.10 minutes.	• ACT teams provide members with an average of two or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. • Ensure services are accurately documented.
S5	Frequency of Contact	1 – 5 1	Staff interviewed reported members are seen three to four times a week. The median weekly in-person contact for ten members was less than one per week (.63). The member record with the highest number of contacts documented for the 30-day period had a total of nine and included one phone meeting with the Psychiatrist, which is considered in-person. Only one member did not have any in-person contacts documented as they were incarcerated. Staff did document four video-conference meetings with that member. In	• Increase the frequency of contact with members, ideally averaging four or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. Ensure staff are trained in appropriate documentation standards and allotted sufficient time to ensure that services delivered are appropriately reflected in the members' medical records in a timely manner.

			response to inquiry about the discrepancy between staff report on the frequency of contact and the results of the ten member records, it was stated that contacts are not being entered into the medical records. There was a total of six videoconference contacts with two incarcerated members, and four other members had phone contact documented. *The fidelity tool does not accommodate delivery of telehealth services.*	
S6	Work with Support System	1 – 5 2	Few members' Natural Supports were identified as being contacted during the program meeting observed. Per data provided, 52 members were identified as having a Natural Support. Several Natural Supports have a dual role as payee or guardian to the member. When that is the case, those supports are also included in treatment planning including hospitalization discharge plans. Natural supports were identified as a valuable resource to the team when struggling to engage members. One member record reviewed included documentation of contact with a Natural Support. Two members interviewed lived with Natural Supports and reported that the team interacts with their Natural Support during home visits. One of these Natural Supports is also the guardian for their family member and reported close contact with the team.	• Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four per month for each member with a support system. • Ensure that all natural support contacts are documented in member records. Some teams review and track these contacts during the program meeting. • Educate members and natural supports on the benefits of collaboration to support members' recovery goals. Some ACT teams describe the PSS as a significant contributor to this effort.
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 4	The team has 49 members with a substance use disorder diagnosis. Observation of the program meeting and a review of member records identified additional members with a co-occurring	• Continue efforts to provide an average of 24 minutes, or more, per week of formal individualized substance use treatment

			disorder that were not included in the 49. Three of the 49 members are engaged in structured individual substance use treatment. Sessions typically range from 30 – 60 minutes each. Members meet with the COS one to two times a month. The COS is not responsible for providing zone coverage although does have members assigned that do not have a co-occurring disorder diagnosis. In addition to a shared online folder with resources provided by the Clinical Director, materials referenced by the COS for individual and group work include a non-specific group therapy homework planner*, The CBT Workbook: A Workbook for Clients and Clinicians, J. Riggenbach,* and *Motivational Interviewing: Helping People Change, W. Miller and S. Rollnick.* Two member records reviewed had documentation of individual treatment sessions.	services for all members with a co-occurring disorder diagnosis. • While the second COS position is vacant, evaluate if COS participation in other duties, e.g., running the program meeting and case management duties, limits the ability to engage or provide individual substance use treatment. Consider shifting those duties to other staff if indicated.
S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	The team offers two co-occurring disorder treatment groups, both named *IDDT*. One group focuses on members in the pre-contemplative and contemplative stages of change and the other is geared toward members in the action and maintenance stages. Groups are in-person at the clinic. It was reported up to six members attend at least one group a month. Sign-in sheets provided listed five (10%) unique ACT members with a co-occurring disorder attended in the month period reviewed.	• Continue to engage members with a co-occurring disorder to participate in group substance use treatment, as appropriate, based on their stage of change. Ideally, 50% or more of applicable members participate in a co-occurring disorder group monthly. • Support the COS to focus on the delivery of co-occurring disorder treatment services to applicable members.
S9	Co-Occurring Disorders Model	1 – 5 3	Training records provided showed several staff participated in recent trainings relating to integrated co-occurring disorder treatment such as, motivational interviewing, co-occurring disorders, substance use and dependence, stages of change, and administering Narcan. The team is	• Provide all ACT team staff with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Treatment for Co-Occurring Disorders, the principles of stage-wise treatment, and motivational interviewing.

			provided training once a month on co-occurring disorders treatment. Several staff acknowledged the team would benefit from more training than what is currently offered. Understanding the value of utilizing a harm reduction approach varied among staff. Some staff identified offering members encouragement and mentoring, and opportunities to talk by phone when needing support. Not all staff interviewed identified reduction of use as the goal. Some staff identified abstinence as the preferred goal after a phase of use reduction. One staff shared that their specific goal for members was to get to a point that they can maintain. Staff will provide information to members on peer-run community groups when requested. The team has not recently referred members to detox but would if medically necessary. The use of recovery language in contact documentation and current treatment plans was inconsistent. Missed opportunities to engage members in substance use treatment were noted by reviewers. However, members' stages of change were identified during the program meeting. The COS does not have responsibility to provide cross-training to FACT 1 staff on an integrated approach to co-occurring disorders, including stage-wise approach, harm reduction, or when it is appropriate to utilize motivational interviewing.	With staff turnover, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. • Support COS staff to provide the team with mentoring and modeling of an integrated co-occurring disorders model. Providing daily support to the team in best practices may improve the level of engagement in services by members.
S10	Role of Consumers on Treatment Team	1 – 5	There are at least two staff on the team with personal lived psychiatric experience. At least one	• Ensure at least one staff person on the team is supported in advocating for

		5	peer shares their story of lived experience with members. It is unclear if those experiences are shared with the team. Staff were unsure how peers advocate, on behalf of members, to the team. Members interviewed were unsure if there were peers on the team.	members from the peer perspective. Peer Support Specialists have specialized training and provide a valuable service to members, member's families, and bring a unique perspective to the clinical team. Peers provide expertise about symptom management and the recovery process; promote a team culture that supports member choice and self-determination; provide peer counseling to members and families; share their story of recovery and practical experience; and carry out other rehabilitation and support functions of the team.
Total Score:		**99**		

ACT FIDELITY SCALE SCORE SHEET

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

5. Responsibility for Hospital Admissions	1-5	3
6. Responsibility for Hospital Discharge Planning	1-5	3
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	1
5. Frequency of Contact	1-5	1
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	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.54**	
Highest Possible Score	**5**	