ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 18, 2020

To: Jessica Bloom, Clinical Coordinator
John Hogeboom, President/CEO

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

Method

On January 21-22, 2020, T.J. Eggsware and Annette Robertson completed a review of the Community Bridges, Inc. (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.

Community Bridges, Inc. (CBI) operates several locations in Arizona. Services include supportive housing, crisis stabilization, integrated healthcare, and ACT. The agency operates three F-ACT teams and three ACT teams in the Central Region of Arizona, including two teams located in Avondale, Arizona, one of which is the Avondale ACT team, the focus of this review.

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

During the site visit, reviewers participated in the following activities:

- Observation of a team meeting on January 21, 2020;
- Individual interviews with the team Clinical Coordinator (i.e., Team Leader), a Substance Abuse Specialist (SAS), the ACT Specialist (AS), and the Rehabilitation Specialist (RS);
- Member interviews: three member group, two member group, and an individual interview;
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of documents, including: 20 sample member calendars, Clinical Coordinator (CC) face-to-face service tracking report, resumes and training records for the SASs and vocational staff, substance use treatment resource, individual and group substance use treatment participation tracking, ACT brochure, member hospitalization/post-hospitalization tracking form, family and friends forum flier, *Re-Engagement-Lack of Contact Checklist*, the Regional Behavioral Health Authority (RBHA) *ACT Admission Criteria*, *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 team is of sufficient size to provide the necessary coverage to the 99 members served. The member-to-staff ratio is about 10:1.
- The team is staffed with two SASs who are able to focus on delivering substance use services to members with co-occurring diagnoses while other team specialists provide on-call and case management support. Staff said that the SASs receive weekly individual supervision from the program's licensed Clinical Lead and participate in monthly supervision with other SASs at the agency.
- Staff is available to provide crisis support and some staff work weekend hours. Team specialists rotate on-call coverage and can meet members in the community. Members said staff provided them with the on-call number.
- The team maintained consistency and continuity of care for members with a low admission and drop-out rate for the period reviewed.
- Most members and all staff interviewed confirmed that there are staff who work on the team with lived experience of substance use and/or psychiatric recovery.

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

- Attempt to identify factors that contributed to staff turnover, or, conversely, supported retention. The members experienced considerable staff turnover in the prior two years. During the year prior to review some positions were vacant for multiple months.
- Explore options to provide full-time psychiatric coverage and a second Nurse. ACT teams with a census around the number of the Avondale team should have full-time Psychiatrist coverage and two Nurses who, ideally, provide community-based services.
- Evaluate what prevented staff from directly supporting members during hospital admissions. Maintain regular contact with members and their support networks, which might result in the identification of issues or concerns that could potentially lead to hospitalization.
- Increase support to members that receive a lower intensity and frequency of service. The ACT team should provide members an average of two hours of face-to-face service time and an average of four or more contacts weekly. Ideally, most services are community-based.
- Increase engagement with natural supports as partners in supporting members' recovery goals. Training staff on strategies for engaging informal support may be helpful. Staff may then be able to advise informal supports on how they can reinforce healthy recovery behaviors or use recovery language when they interact with members.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 99 members with ten staff that provide direct services, excluding the Psychiatrist, resulting in a member to staff ratio of 10:1.	
H2	Team Approach	1 – 5 4	Staff said that all members likely receive face-to-face contact with multiple staff in a two week period. Staff track contacts at the team meeting. Staff are assigned caseloads for completing home visits, and paperwork, but other staff can fill-in if the primary assigned staff is unavailable. Members interviewed reported meeting with two to six staff during the prior week. Based on sample records, 70% 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	Per staff report, all members are discussed during the program meeting held five days a week. During the Wednesday meeting staff discuss members with more acute challenges. During the meeting observed, all members were discussed. The Program Assistant listed members for discussion. Staff contributed by reporting on recent or planned contact with members, the provision of substance use treatment, medication services, some independent living skill assistance and general case management activities. The Nurse and specialists attend the team meeting on the weekdays they are scheduled to work but a Psychiatrist does not regularly attend.	• An ACT Psychiatrist should attend at least one program meeting weekly where all members are discussed.
H4	Practicing ACT Leader	1 – 5 4	The CC reported providing direct services 23% - 25% of the time. The CC reported meeting with members in the office to update their treatment plans and assisting members to meet with covering Psychiatrists via videoconference. In ten records there were examples of office-based CC	• Optimally, the CC's delivery of direct services to members should account for at least 50% of the time. • Identify administrative tasks currently performed by the CC that may be transitioned to other administrative or

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			services over a recent month. Based on review of a productivity report, the CC provided direct services nearly 28% of the time over a recent month.	support staff.
H5	Continuity of Staffing	1 – 5 2	Based on data provided, 17 staff left the team in the most recent two-year period, a turnover rate of about 71%. During the two years prior to review multiple staff filled the role of Psychiatrist, Independent Living Skills Specialist (ILS), Housing specialist (HS), Nurse, RS, and SAS.	• Attempt to identify factors that contributed to staff turnover or supported retention. Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their supports.
H6	Staff Capacity	1 – 5 4	The team operated at about 80% of staff capacity over the prior year. There was a total of 29 months with position vacancies. Positions vacant for multiple months include: Nurse, Peer Support Specialist (PSS), HS, ILS, SAS, and Psychiatrist.	• Continue efforts to screen potential hires for the responsibilities of ACT services. • Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually.
H7	Psychiatrist on Team	1 – 5 1	The previous Psychiatrist left the team late November 2019. Staff said that the team relies on coverage from another agency Psychiatrist. Documentation from two Psychiatrists was found in ten member records over a recent month period. Some members reported that three different Psychiatrists worked on the team over the prior year. One member gave an example of how changeover in Psychiatrists prevented the member from resolving a paperwork issue. Members said they usually meet with a Psychiatrist monthly via videoconference at the office. Some members voiced their preference to meet with a Psychiatrist face-to-face.	• Consider options for providing full-time psychiatric coverage. ACT teams with a census around the number of the Avondale team should have a full-time Psychiatrist. Ideally, the ACT Psychiatrist is available to provide community-based services. • Evaluate options to address the concerns of members who prefer face-to-face psychiatric services. • Optimally, an ACT Psychiatrist is available to spontaneously collaborate with nursing staff, and to provide education to other specialists on medications, side effects and health issues that member's experience.
H8	Nurse on Team	1 – 5 3	Staff said that the single team Nurse is available to staff during and after business hours. No examples of community-based nursing services were found in the records reviewed. Staff said that the Nurse provides most services in the office, such as dispensing medications, providing injections and	• Consider options for adding a second Nurse. ACT teams serving the number of members around that of the Avondale team should have two full-time Nurses. Having two Nurses should ideally allow flexibility for ACT Nurses to provide

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			arranging for member transportation. The reviewers found three examples in sample records of non-ACT staff providing nursing services. A second Nurse was with the team part of the month of November 2019, but the position was otherwise vacant since March 2019.	community-based services.
H9	Substance Abuse Specialist on Team	1 – 5 5	The team is staffed with two SASs. Both SASs completed Master of Social Work (MSW) programs. One SAS joined the team January 2019 and the second joined the team April 2019. Previously, the second SAS worked with a different agency for about six years providing treatment to dually diagnosed adults. Staff said that the SASs receive weekly individual supervision from the program's Clinical Lead. The Clinical Lead is a Licensed Professional Counselor. Staff said that the SASs meet as a group for monthly supervision and talk about strategies to engage and work with members, interventions, and self-care.	
H10	Vocational Specialist on Team	1 – 5 5	The team employs an Employment Specialist (ES), with the team since June 2017, and an RS who joined the team April 2019. The RS worked on another ACT team at the agency as an RS from August 2014 to June 2016. Staff said that RBHA staff provides on-site vocational training every three months, but neither vocational staff have attended consistently. Staff reported that on-line trainings are available. Training records showed that the ES participated in little training in vocational services. The RS participated in Rehabilitation Services trainings for 12 total hours.	• Ensure that both vocational staff receive regular training in assisting people diagnosed with a serious mental illness (SMI)/co-occurring disorders, to find and retain employment in integrated settings.
H11	Program Size	1 – 5 5	At the time of review, with ten staff, the team is of adequate size to provide coverage to the 99 members.	
O1	Explicit Admission	1 – 5	Staff said that members are referred to the team	

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	Criteria	5	through the RBHA, other teams, or other providers. The CC or another staff meets with potential ACT members to complete a screening using the RBHA developed *ACT Admission Criteria*. The screening information is reviewed by the CC and Psychiatrist to determine if members are eligible to 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 was five members during July 2019, followed by three admissions August 2019, and two admissions October 2019. One member joined the team December 2019 and zero joined each month of September and November 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides case management, employment and rehabilitative support, most substance use treatment, the majority of psychiatric and medication services, and counseling is available. Staff said that about ten members receive counseling through the SASs on the team and no members receive counseling from brokered providers. In a record reviewed, vocational staff documented providing education to a member about applying for a job, conducting face-to-face contact with a potential employer, and assisted the member with an online job application. Staff reported one member participates in Work Adjustment Training (WAT) with a brokered provider. Staff said that the member started the WAT before joining the team. Primarily the Nurse, with assistance from the CC, serves as liaison to coordinate psychiatric and medication services. The team has no permanent	• Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff providing housing support. Enlist natural supports as a resource to assist in identifying housing options. • Ensure ACT staff coordinate treatment and services delivered to members who receive support from other CBI programs.

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			Psychiatrist and relies on coverage from other agency staff. In records, at least one of the ten members did not meet with a Psychiatrist in a month period. The member was in contact with the team and was not incarcerated. In records, the reviewers found examples of staff who are not on the ACT team providing nursing services. The SASs provide individual and group substance use treatment. Staff said that three members with co-occurring diagnoses receive medication-assisted treatment (MAT) through a CBI program that is separate from the ACT team. Staff from the separate program documented in a record reviewed of a member's participation in group treatment. It was not clear if ACT staff coordinated services with the program staff. Staff said that members transition off the team after 30 days in residential treatment. Based on staff interviews, 17% - 19% of members reside in staffed locations, including about five in treatment settings affiliated with the RBHA's system of care and other less formal staffed settings. One member was mandated through the legal system to receive residential substance use treatment. One staff reported a member resided in a private pay group home before joining the team.	
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the team is available to provide crisis services 24 hours a day, seven days a week, including responding to members in the community. Four specialists and the Nurse work weekend shifts. On-call coverage rotates among specialists daily and once every six weeks a staff is on-call twice during the same week. The CC is available to consult with on-call staff and serves as	

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			back-up for after hour calls. Staff are not allowed to transport members in their personal vehicles. If staff need to transport a member, they travel to a local CBI office to obtain a fleet vehicle. 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. A member interviewed voiced that certain staff do not answer the phone or respond when on-call.	
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 services. Staff monitors hospitalization services using a tracking form. During office hours, staff attempt to arrange for members to meet with the Psychiatrist for assessment prior to admission and are available after hours to support members in the community or with inpatient admissions. Staff reported that they meet with members within 24 hours of being informed of an admission and every 72 hours thereafter. Staff said that the covering Psychiatrist attempts doctor-to-doctor consultations with inpatient providers. Based on review of ten recent member psychiatric hospital admissions, the team was directly involved in few. The team brought one of the members to the hospital. Two members received ambulance transportation, and it appears staff were involved in one of those admissions. Three members self-admitted without informing the team and one member was petitioned by Police Officers. Three members admitted into the CBI Access Point facility for crisis stabilization and assessment without team involvement. It does not	• Evaluate what contributed to members not seeking team support prior to self-admissions. • Maintain regular contact with all members and their support networks (both informal/natural and formal). This may result in identification of issues or concerns allowing the team to offer additional supports, which may reduce the need for hospitalization. • Consider implementing a process for ACT staff to have the opportunity to engage with ACT members before they self-admit to Access Point. • Consider if member treatment plans should be revised to address behaviors and/or circumstances related to self-admissions.

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			appear that there is a process in place for ACT staff to engage with members in the lobby at Access Point after hours before admission.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that they coordinate with inpatient staff when members are inpatient. Staff said that the team was directly involved in the ten most recent hospital discharges. Two of the ten members elected to have informal supports be present and provide transportation at discharge. Staff said they coordinated the member discharges in advance. Staff from the team usually meets members at discharge to provide transportation. Staff tracks post-hospitalization services on a tracking form that prompts for the member to have a scheduled Psychiatrist appointment within 72 hours and Nurse appointment within ten days of discharge. Staff attempt face-to-face contact with members for five days after discharge.	
O7	Time-unlimited Services	1 – 5 5	Staff reported that over the prior year, three members graduated from the team and projected four or five graduates in the upcoming year. Staff uses the RBHA's *ACT EXIT Criteria Screening Tool* to evaluate members for discharge/transition. Staff said that an Adult Recovery Team (ART) meeting is held with members and their natural supports when planning for transition off the team. The team reviews the member's progress toward goals, modifies the member's treatment plan to reflect the reduced services, and plans with members to transition services.	
S1	Community-based Services	1 – 5 3	Staff interviewed estimated spending 80% - 95% of their time in the community. Two members interviewed reported that they meet with staff more often in the community than in the office. Per the record review, 58% of face-to-face	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. • If new group activities are developed, avoid

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			contacts with members occurred in the community. Substance use treatment groups are held at the office, but the team does not rely on other clinic-based groups to maintain contact with members. Staff has access to an application on their phones enabling them to dictate their accounts of services which are transmitted to member electronic records.	over-reliance on clinic contacts with members as a replacement for community-based contacts. Provide individualized services to support members to achieve their goals.
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the year prior to review, two members transitioned to *Navigator* status: one refused services and one could not be located. Three members left the service area and were referred to new providers and one member was offered a referral but declined assistance. A member receiving services from another system of care transitioned off the team and seven members were sentenced to prison.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The team uses an eight-week outreach strategy and checklist to track their efforts. The checklist prompts to ensure a range of efforts occur, such as contacting the member's Probation Officer, involved family, and emergency contacts, as applicable. The checklist includes phone numbers for hospitals, shelters, and jail information. Staff said that outreach they conduct includes contacting members' natural supports, coordinating with payees and by visiting members at their homes and locations where they are known to visit. Staff reported no members receive services through the Division of Developmental Disabilities. There were lapses in documented outreach or contact with members found in member records reviewed. For one member, 13 days lapsed	• Monitor documented outreach and contacts with members and evaluate the team's approach to building rapport with disengaged members. It may be useful to assign a staff to spot-check documentation in member records during the team meeting to confirm recent contacts or that outreach efforts are documented. This may enable the team to proactively assign staff to outreach members in the event of lapses in contact. • Continue efforts to involve informal supports as team partners in supporting members' recovery goals.

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			between contact or outreach. Following contact with the member, nine days passed before the next outreach. During that time, the member missed an appointment and it was not clear if staff attempted follow-up for at least five days. Staff documented two contacts and two outreach attempts over 14 days for one member. For another member 14 days lapsed between contact or outreach. Staff documented an average of one weekly attempted visit with an incarcerated member during a month period. However, more than a week passed with no attempted visit. The team may miss opportunities for engagement. For example, one member with a substance use diagnosis did not receive individual treatment nor was it offered over a month time period but medication support was provided.	
S4	Intensity of Services	1 – 5 2	Per the review of ten member records, the median intensity of service time per member was 28 minutes weekly. One of the ten members received an average of 124 minutes per week but seven received less than 50 minutes average time.	• 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 2	Sample member calendars showed that few members regularly received three or more contacts weekly. The median weekly face-to-face contact was just under 1.4 per member based on records reviewed. Two members received an average of four or more contacts per week, with most of the contacts occurring in the community. However, five members received an average of less than one contact per week. Staff document interactions under separate codes based on services rendered. When multiple notes document the same interaction they are considered one contact for the purposes of this review.	• Identify and resolve barriers to increasing contacts with members. Optimally, members receive an average of four or more face-to-face contacts a week.

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S6	Work with Support System	1 – 5 2	Staff interviewed estimates of members on the team with natural supports ranged from 10% to about 50%. Staff said that the team attempts at least weekly contact with members' support systems and may have multiple weekly contacts. One member said that staff works closely with their informal support that sometimes relies on staff to relay messages during periods when the member is unsheltered. Other members identified no natural supports or prefer that staff not contact their supports. The agency offers a monthly family and friends forum where supports can learn about the system of care, resources, medications and side effects, and have the opportunity to build mutual supports. One staff gave an example of a member's natural supports who regularly attends the forum. During the team meeting, staff discussed recent or planned contacts with informal supports for ten members. In ten records reviewed, staff documented five contacts with member supports: two times each for two members, and once for another member.	• The team may benefit from further training on strategies to assist members in building and engaging natural supports. • 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.
S7	Individualized Substance Abuse Treatment	1 – 5 4	A staff reported that the SASs meet weekly with about 40 of the 71 members with co-occurring diagnoses. Another staff reported around 20-30 members receive individual weekly treatment but that around 60 were engaged over a recent month period. Some members are incarcerated and may meet with another specialist during visits. Data showed eight of the ten members in the record sample have a substance use diagnosis. Documentation in records of individual treatment showed assessments of members during contacts	• 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 across the group of members with co-occurring diagnoses. • Evaluate if SASs engage in other duties, such as to members who do not have co-occurring diagnoses. Consider shifting those duties to other staff, if applicable.

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			and the assessed stage of change. The SASs documented discussions with members that included: decision making, cited the use of open ended questions, reflective listening and summarizing to help with identifying coping techniques when exposed to triggers or experiencing the desire to use substances. Staff engaged members to identify goals to work toward as alternatives to substance use. Over a month period, sessions per member ranged between zero with two members and three with one member. Five members received one session each, but for one of those members staff documented two additional attempts. Staff said session times range from 30-60 minutes, with most at around 30 minutes. In records, session time ranged from nine to 60 minutes, and the average was about 36 minutes. Individual session tracking was provided for a recent month period. The data showed sessions in 15 minute increments, not actual service time. Based on the average session time in records, and the individual treatment tracking data, the SASs provided approximately 11 minutes of substance use treatment weekly on average to members with co-occurring diagnoses. Each SAS had four days of time-off during the month period reviewed.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff said that each SAS facilitates a weekly co-occurring treatment group. One group is directed to members in earlier stages of treatment and one is targeted to members in later stages of recovery. Staff reported eight to twelve members attended at least one group over a recent month time period. Documentation in sample records showed	• Staff should continue to engage dually diagnosed 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

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			staff inviting members to substance use treatment groups and one of eight applicable members attended a group. Based on review of co-occurring treatment group sign-in sheets over a recent month period, about 7% of ACT members with co-occurring diagnoses attended at least once.	may benefit from training on strategies to engage members in group substance use treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Staff reported that the team uses Integrated Dual Disorders Treatment (IDDT), an evidence-based practice for members with co-occurring SMI and substance use diagnoses. The SASs draw from the *Recovery Life Skills Program*. Training records showed that staff received training for Integrated Treatment for Co-Occurring Disorders and Motivational Interviewing but not IDDT. However, staff appears to be familiar with stage-wise treatment. Staff gave examples of interventions for different stages of treatment. During the meeting observed, the SASs referenced individual and group substance use treatment, engagement, and identified members' stages of change. Staff interviewed gave examples of harm reduction, including making Narcan available to a member and their natural support, encouraging safer intercourse practices, and working with a member to reduce the amount of substances purchased over a month period. Posted in multiple locations at the agency was an overdose risk alert. The posting identified options for those at risk to consider, such as not using substances alone or making a plan in advance for supports to check-in with those individuals. The posting identifies a number to contact to request naloxone and/or fentanyl test kits. During the team meeting, staff identified the plan to work with a member to develop an *Honest Monthly Budget*.	• Provide ongoing guidance to staff in the identified co-occurring treatment approach, IDDT. This may help the staff to provide consistent service if SASs transition off the team. • Ensure member treatment plans identify member goals and individualized needs. Ensure members have the ability to identify goals to reduce use if sobriety is not their explicit goal.

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			Staff said that the team does not refer to Alcoholics Anonymous (AA) or similar groups but that they assist members to locate options if they are interested. Staff identified circumstances when the team might refer members for medical withdrawal management and gave examples of substances likely to require that support. In records, seven of eight applicable member treatment plans addressed substance use with the goal of sobriety listed. One plan identified that an SAS would work with a member to address past trauma. Five of the treatment plans seemed to reflect members' goals and individualized needs. Two treatment plans seemed to be written from the team perspective. For example, one plan listed the goal to "achieve sobriety through planned intervention and provided resources."	
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff reported that multiple ACT employees have lived experience of substance use and/or psychiatric recovery. Most members interviewed confirmed that there are staff who work on the team with lived experience of substance use and/or psychiatric recovery. Some members affirmed the benefit of receiving support from ACT staff who share similar lived experience.	
Total Score:		**3.79**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
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	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.79**	
Highest Possible Score	**5**	