ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: March 22, 2023

To: Amy Viets, Clinical Coordinator
Winona Belmonte, MD
Shar Najafi-Piper, CEO

From: Nicole Eastin, BS
Jasmine Davis, MS
AHCCCS Fidelity Reviewers

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 February 14 – 15, 2023, Fidelity Reviewers completed a review of the Copa Health Metro Omega 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.

Copa Health operates several outpatient centers. Copa Health offers employment-related services, day program activities, integrated health, and residential services. The individuals served through the agency are referred to as members.

The SAMHSA ACT Fidelity Review tool does not accommodate the 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 an ACT team program meeting on February 14, 2023.
- Individual video conference interview with the Clinical Coordinator (CC).
- Individual video conference interviews with ACT Counselor, Nurse, and the Co-Occurring, Housing, and ACT Specialists for the team.

- Individual phone interviews with three members 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: *Mercy Care ACT Admission Criteria; ACT Contact and Fidelity Guidelines; Omega ACT Team Phone Numbers;* resumes and training records for Co-Occurring Specialist staff; substance use treatment resources; sign-in sheets for co-occurring disorder treatment groups; Co-Occurring members' calendars; ACT team member roster; identification of Natural Supports; and CC Productivity Report.

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 ACT CC is highly engaged in providing direct services to members of the ACT team. The CC's productivity for a month period showed a high rate of in-person services delivered.
- The ACT Psychiatrist is fully dedicated to the ACT team and is accessible to staff and members including after hours and weekends. Additionally, the Psychiatrist provides services in the community.
- The team is available to provide crisis support by phone and in the community after business hours and provides weekend coverage. Members interviewed were knowledgeable of the team's availability and contact information after hours and on weekends.

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

- At the time of the review, the two Vocational Specialist positions were vacant. Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met.
- Optimally, 80% of ACT services are delivered in the community where challenges are more likely to occur. With a low median percentage of services provided in the community based on the records reviewed, it will be beneficial to shift service from the clinic to the community.
- Few members with a co-occurring disorder attend the Co-occurring treatment group provided by the team. Staff should continue to engage members with a co-occurring disorder to participate in group substance use treatment, as appropriate, based on their stage of change.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, there were nine full-time equivalent (FTE) staff on the team, excluding the Psychiatrist and Program Assistant. It was reported that there are 95 members on the team, leaving a member-to-staff ratio of approximately 11:1. The direct staff includes the CC, ACT Specialist, two Nurses, two Co-Occurring Specialists (COS), Housing Specialist, Independent Living Specialist, and Peer Support Specialist (PSS). A counselor is assigned to the team 20%, but does not attend the treatment team meeting, and thus is not included in the calculation as a member of the direct staff team.	• 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 3	Staff interviewed reported that they are assigned a caseload for administrative purposes but are also required to see assigned members weekly. Staff also complete a weekly rotation schedule to ensure all members are seen by two staff weekly. The CC stated 75 - 80% of members are seen by more than two staff per week. Members interviewed reported seeing two to four staff per week. Per review of ten randomly selected member records, for a two-week period, 60% of members received in-person contact from more than one ACT staff.	• Ideally, 90% of ACT members have contact with more than one staff in a two-week period. Continue efforts to ensure all members on the ACT roster have in-person contact with more than one staff in two weeks; a diversity of staff allows members access to unique perspectives and expertise of staff.
H3	Program Meeting	1 – 5 5	Staff reported the ACT team meets four days a week, Tuesday through Friday. The Psychiatrist attends at least once a week, usually on Tuesdays. Although the Nurse is scheduled to attend the meeting four days a week, they are providing services to members while	

			onboarding the second Nurse. In the meeting observed by reviewers via videoconference, staff reported on member last contact and planned contact for the week, as well as group engagement, medication monitoring, services provided by the Psychiatrist and Nurse, and employment engagement. The COS staff identified members' Stage of Change for those receiving individual treatment sessions.	
H4	Practicing ACT Leader	1 - 5 5	The CC estimates providing direct services 20 – 22 hours per week. Staff reported that the CC is readily available to staff and members. Documentation of the CC's productivity for a month period showed an average of 72 hours of in-person services delivered. In the ten records reviewed, there were 31 examples of the CC delivering services which included meeting with members at their home during the weekend, videoconference with an incarcerated member, and providing engagement and support at the clinic.	
H5	Continuity of Staffing	1 – 5 3	Based on the information provided, the team experienced a turnover of 50% in the past 24 months. A total of 12 staff left the team during this period. The Nurse position had the highest turnover for the second year in a row.	• If not done so already, consider examining employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention. • ACT teams should aim for a turnover rate of less than 20% over a two-year period. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.
H6	Staff Capacity	1 - 5 3	In the past 12 months, the ACT team operated at approximately 72% of full staffing capacity. The PSS, Nurse, COS, and Employment Specialist positions were vacant for multiple months.	• 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 5	The Psychiatrist on the team is the agency's Assistant Medical Director and provides temporary coverage for another ACT team located at the same clinic	

			location one day a week. However, per staff report, these responsibilities do not interfere with the coverage provided to this ACT team. The Psychiatrist, working a six-day work week, provides services to members of this ACT team in-person at the clinic and in the community, and via teleconference five days a week. Staff interviewed reported the Psychiatrist is readily available including after-hours and weekends. Per ten member records reviewed over a 30-day period, the Psychiatrist was active with nine members in-person at the clinic, in the community, and via teleconference, including the weekends. This is consistent with staff and member reports of the Psychiatrist seeing members monthly. One member interviewed reported the Psychiatrist has an upcoming appointment scheduled in the community in an effort to support them.	
H8	Nurse on Team	1 – 5 5	The ACT team has two Nurses assigned to the team; one recently joined the team in January 2022 and will be focused on providing services in the community. The other Nurse has been with the team since November 2020. Staff interviewed reported that the Nurses are readily accessible to the team by phone, email, and in person, and are available after hours and weekends. The Nurses deliver services to members at the clinic and in the community providing medication education, administering injections, completing annual EKGs and lab draws, monitoring symptoms, Nurse to Nurse coordination with inpatient facilities, and accompanying members to specialty medical appointments.	

			Members interviewed reported meeting with the Nurse weekly to once a month at the clinic.	
H9	Co-Occurring Specialist on Team	1 – 5 4	The team has two Co-Occurring Specialists. One joined the team in October of 2022 and the other at the end of January 2023. Per training records and resumes, one COS has experience providing substance use treatment services prior to joining the ACT team and completed one Integrated Dual Disorder Treatment training with Copa Health. The other COS has several years' experience providing individual and group substance use treatment services to individuals with a serious mental illness. Training records provided for this COS were not recent experiences. The COS are provided clinical group supervision weekly by a Licensed Professional Counselor from Copa Health.	• Provide annual training to COS in co-occurring treatment best practices, including appropriate interventions, i.e., stage wise approach, based on members' stage of change. • Continue to provide COS with supervision by qualified staff and guidance in co-occurring treatment best practices. Optimally, consistent evidence-based co-occurring treatment information is provided and then disseminated to other ACT staff through cross-training.
H10	Vocational Specialist on Team	1 – 5 1	At the time of the review, the two Vocational Specialist positions were vacant.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met.
H11	Program Size	1 – 5 5	The ACT team is adequately staffed with 10 staff to serve the 95 members assigned to the team. Two positions were vacant at the time of the review, the Rehabilitation and Employment Specialist.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team has a clearly defined target population. Based on ACT staff interviews, members are referred by the Regional Behavioral Health Authority, other teams from within the agency, psychiatric inpatient facilities, and other providers. Staff reported the CC, and/or an ACT staff conduct screenings of members referred. The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions within 48 hours of the referral. When the screening is complete, the member is staffed with the CC and Psychiatrist. The Psychiatrist makes the final decision	

			if the member is appropriate for the team. At the time of the review, the ACT team had a waitlist for potential new admissions, with five new members slotted to join the team in the following weeks.	
O2	Intake Rate	1 – 5 5	Per data provided, and reviewed with staff, the team has an appropriate rate of admissions. The month with the highest rate of admissions during the past six months was September with three new members added to the team roster.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team directly provides substance use treatment services and psychiatric and medication services. No members of the ACT team receive psychiatric services outside of the ACT team. The team has COS staff that provide both individual and group substance use treatment to members. The team has at least two members receiving employment and rehabilitation services from a brokered provider. At the time of the review, staff reported that the team is supporting six members in their job search and 10 – 15 members in maintaining employment. Members interviewed reported ACT staff would assist in employment and rehabilitative services should they choose to engage in those services. The team does have a Licensed Associate Counselor partially allocated, 20%, to provide counseling and psychotherapy to members of the ACT team. It was reported six members are engaged in those services; however, this staff member does not attend treatment team meetings. Additionally, approximately four members are receiving counseling services off the team from another Copa	• Support the LAC to attend a minimum of two program meetings a week to support the coordination of member care. • Track the number of members in staffed residences. To the extent possible, ACT staff 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, no more than 10% of ACT members are in settings where other social services staff provides support. • ACT staff should first engage directly with members to support rehabilitation and competitive employment goals rather than refer to outside resources. Continue efforts to offer individualized engagement and assistance.

			Health agency staff for specialty treatment relating to trauma, or when the partially allocated Counselor's caseload is at capacity. Two members interviewed reported being supported by the ACT team with obtaining their current housing. Yet, based on staff interviews and charts reviewed, the team has between 9 - 15 members residing in settings where ACT services are duplicated.	
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the ACT team is available to provide crisis services 24 hours a day, seven days a week. Staff reported the team rotates on-call responsibilities weekly and the CC serves as the back-up. Staff provided a copy of the *Omega ACT Team Phone Numbers* given to members and natural supports that lists the on-call number, on-call backup, as well as numbers for each of the ACT Specialists, Program Assistant, and the CC. Staff reported member crisis calls resulting in staff to go out in the community does not occur often, until two weeks prior to the review, the team had not responded to a community crisis call for 8 – 9 months. All members interviewed were aware of the team's availability after hours and weekends. One member reported texting the CC to check in on the weekends to let them know they are doing okay. In two member records reviewed, staff documented reminding a member and their natural support of the team's availability after hours and weekends providing the on-call and staff contact information.	
O5	Responsibility for Hospital Admissions	1 - 5 4	Based on data provided and reviewed with staff, the team was directly involved in 90% of the most recent member psychiatric hospital admissions. These	• Maintain regular contact with all members and their support networks. This may result in early identification of issues or concerns

			admissions occurred over a three-month period. One member self-admitted to an inpatient facility. Staff interviewed reported that during business hours when members are experiencing an increase in symptoms or request to go to the hospital, the team will ask the member to meet with the Nurse or Psychiatrist to assess the situation and determine the best level of care. Staff reported at times members may just need a safe place to stay and assistance with locating a respite program rather than inpatient care. After hours, staff will attempt to de-escalate the member over the phone and if it is determined that staff should meet the member in the community, staff will contact the CC to advise of the situation. If a situation is safe, staff will transport the member to a hospital. The team will provide the inpatient team with a medication list, the last date of injection if applicable, and the ACT team contact information. Staff will stay with the member until admitted, if allowed by the hospital. As soon as a member is admitted, the CC or Nurse will reach out to the inpatient treatment team to obtain the treating Doctor and Nurse information to ensure coordination of care occurs within 24 – 48 hours of admission. Staff interviewed reported the goal is to see members three times a week while inpatient. Staffings occur weekly in-person, via teleconference, or by phone, varying by the facility. Per the *ACT Contact and Fidelity Guidelines* provided, members are to be seen in-person within 24 hours of admission and every 72 hours minimum by ACT staff. Of two member records with recent hospital admissions, based on documentation, the team did	that could lead to hospitalization allowing the team to offer additional supports which may result in a reduced need for hospitalization. Continue to educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions.

			not consistently follow the protocol described during interviews.	
O6	Responsibility for Hospital Discharge Planning	1 - 5 4	Based on data provided and reviewed with staff, the team was directly involved in 80% of the most recent member psychiatric hospital discharges. One member was provided a bus pass by the inpatient team and discharged despite the team not being in agreement. Another member left the facility against medical advice. Staff interviewed reported one day prior to discharge, the team attempts to obtain discharge paperwork to allow time to work with the agency pharmacy to order and fill medications. The team follows a five-day follow-up protocol which includes five days of in-person contact, then a minimum of once a week in-person contact for the next four weeks. The member is scheduled with the Psychiatrist within 72 hours of discharge and within one week with the Nurse. Based on the charts reviewed of discharged members, both members were discharged and transported to the clinic by ACT staff and seen by the Psychiatrist and the Nurse. One member was seen in person by ACT staff for four of the five-day follow up protocol and the other member was seen two of the five days with attempted home and community visits for three days.	• Continue to coordinate with inpatient staff, members, and their supports (both natural and formal) to reinforce the benefits of including the team in hospital discharges, highlighting how the team can increase supports after discharge.
O7	Time-unlimited Services	1 – 5 5	Data provided to reviewers showed that the ACT team graduated four members in the last 12 months. The team measures readiness for graduation by discussing the level of services the members are requiring from the ACT team. Discussion includes progress the member has made based on medication	

			and appointment adherence, housing stability, independent living skills, and no recent hospitalizations or crisis interventions with the Psychiatrist as the deciding factor. The team then has a discussion with the member about graduating from the ACT team and begins reducing contact with the member when in agreement. Staff indicated it can be difficult to discharge members to a lower level of care, as members appreciate the support of the ACT team.	
S1	Community-based Services	1 – 5 1	Staff interviewed reported 70% of in-person contact with members occurs in the community. However, the results of ten randomly selected member records reviewed show staff provided services a median of 17% of the time in the community. Members interviewed provided a range of being seen in the community from once a week, month, or quarter, noting most often contacts occur at the clinic.	• Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts. Optimally, 80% or more of services occur in members' communities. Increase the delivery of services to members in their communities. • Ensure all staff engage members in the community at a similar level as what was reported by staff interviewed.
S2	No Drop-out Policy	1 – 5 5	According to data provided, the team retained nearly 100% of the members in the past 12 months, with two members dropping out of the program.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff interviewed reported when members are not in contact with the team, outreach is completed four times a week for eight weeks with two of those attempts being in the community. Staff provided explanation of outreach and engagement efforts including member's last known address, known hang outs, shelters, gas stations, and reaching out to jails, hospitals, medical examiner's office, natural supports, payees, and probation officers. Of the records reviewed, one showed ACT staff completing outreach two to three times per week for four weeks, at local parks, shelters, members' last	

			known address, medical examiner's website, and contacted hospitals. Another record reviewed showed staff attempting a home visit with a member for medication observation, the member was not home the first time, staff returned to the home later in the evening to attempt again, attempted phone calls to the member by ACT staff was also completed. One member was incarcerated, more than one staff from the team completed weekly video visits with the member for continued engagement.	
S4	Intensity of Services	1 – 5 4	Per a 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 87.13 minutes. The highest rate of intensity was 338.5 minutes a week, as the team provided daily medication observation. Two member records reviewed indicated the lowest rate of intensity of zero minutes a week. One member was on outreach for the full period and the other was incarcerated, however, the team completed weekly videoconference jail visits with that member. The Psychiatrist delivered teleconference services twice in the month period reviewed. *The fidelity tool does not accommodate delivery of telehealth services.*	• Continue efforts to provide intensive services to members. ACT teams should provide an average of 2 or more hours of in-person services per week to help members with serious symptoms maintain 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 4	Of the ten records randomly sampled, ACT staff provided a median frequency of 3.13 in-person contacts to members per week. Four member's charts reviewed had four or more in-person contacts per week. Five members had phone contact documented in the records.	• Continue to increase the frequency of contact with members by ACT staff, preferably averaging 4 or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have different needs/goals and frequency of

				contact should be determined by those needs and immediacy.
S6	Work with Support System	1 – 5 3	Per data provided, 61 members have a natural support, however, per staff interviews, the team has regular contact with less than half. Other staff identified natural supports as members' emergency contacts only. One staff reported when members live with their natural supports and are considered their emergency contact only, the team still engages to determine if there may be questions or concerns about the member, but otherwise do not contact them. Another staff reported that when members' natural supports are not involved day to day and are only listed as their emergency contact, contact is not made unless the member is on outreach or there is an emergency. During the program meeting observed, contacts with natural supports were identified for at least eight members. Staff reported the team is utilizing a new system to track natural support contact and the goal is weekly contact with involved natural supports. However, staff estimated that contact occurs at least twice a month by phone, or in-person when members live with their natural supports. Of the members interviewed, one reported recently updating their emergency contact with the team and will only have contact when necessary, another member reported the team does not have contact with their natural support, and another member was not sure how often the team had contact with their natural support, however, indicated the team engages with their natural support when conducting home visits.	• Increase contacts with natural supports to an average of four per month for each member with a support system. As much as possible, contacts with natural supports should occur during the natural course of delivery of services provided to members. • Assist members in developing a natural, community-based support system. Active participation with peer run programs are a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact.

			Per records reviewed, there were nineteen contacts documented with natural supports within the month period reviewed, an average of 1.90. Examples of contact with natural supports included medication education, inviting to a staffing to support treatment goals, discussing increased symptoms, discussion of placement post-hospital discharge, and appointment reminders.	
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 4	The COS interviewed reported utilizing the *Integrated Co-Occurring Disorders Treatment (ICDT) model*, harm reduction, motivational interviewing strategies, and a stage-wise approach to provide treatment services to members with a co-occurring disorder. Per interviews and data provided, there are 59 members on the team identified with a co-occurring disorder. Staff reported that 20 to 24 members receive individual co-occurring disorder treatment weekly. Some may meet more frequently. Sessions range from 30 to 45 minutes each. Of the ten records reviewed, six members were identified as having a co-occurring disorder diagnosis. Of those, three members were engaged with the COS for one-to-one sessions with the majority of those ranging 23 to 41 minutes, including weekly one-to-one sessions with an incarcerated member. One member record showed 128 minutes of an ICDT session with the COS. Member calendars of those engaged in individual co-occurring disorder treatment showed members were engaged weekly to once a month ranging from 23 to 90 minutes.	• Continue efforts to increase the time spent in individual treatment sessions and increase the number of members engaged so that the average time is 24 minutes or more per week for all members with co-occurring disorder diagnoses. • Evaluate if COS participation in other duties, such as medication observation, limits the ability to engage or provide individual substance use treatment. Consider shifting those duties to other staff if indicated. • Refer to recommendations in item *H9, Co-Occurring Specialist on Team.*
S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	At the time of the review, one co-occurring disorder treatment group was offered to ACT members weekly. Staff interviewed reported after the second COS completes training; another group will be added	• Engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally,

			weekly. Based on staff interviews, 6 to 10 members regularly attend the group weekly. Based on the review of co-occurring diagnosis treatment group sign-in sheets for the month prior to the review, 7% of ACT members with a co-occurring diagnosis attended at least one co-occurring disorder group.	50% or more of applicable members participate in a co-occurring group. • Consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach, utilizing best practices in co-occurring disorder treatment.
S9	Co-Occurring Disorders Model	1 – 5 4	All staff interviewed reported supporting members in reducing use of substances and gave examples of harm reduction tactics. In addition, staff reported utilizing motivational interviewing strategies and attempt to "meet the member where they are at" in a non-judgmental approach. Not all staff interviewed were not familiar with the principles of a stage-wise treatment approach to interventions. Staff reported encouraging members with a co-occurring disorder to participate in individual or group treatment. Staff do not refer members to peer-run substance use programs but will support members that request to attend, as observed in one chart reviewed. One member interviewed reported the Psychiatrist is scheduled to attend a peer-run substance use treatment meeting with them in the upcoming month. When members request detoxification services, the team will refer them to local resources which was also observed in one chart reviewed. Based on the records reviewed, of the six members listed on the COD roster, four members' treatment plans reflected goals to support the members in substance use treatment. Three plans indicated the framework and services to be delivered by the COS.	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Treatment for Co-Occurring Disorders, in the principles of stage-wise treatment, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Adhering to a co-occurring disorder model within the team can promote continuity in the approaches ACT specialists utilize when supporting members.
S10	Role of Consumers on Treatment Team	1 – 5	Staff interviewed reported that at least one staff on the team has lived psychiatric experience and shares	

		5	their story with members when appropriate. Staff reported that the PSS offers insight to the team on services that were helpful to them in their own recovery and provides the team with a perspective as a peer that helps deliver services to members. Members interviewed were knowledgeable of more than one staff on the team with lived psychiatric experience and reported that the staff shares their story. One member reported it is helpful when staff can relate to their own experiences.	
Total Score:		**111**		

ACT FIDELITY SCALE SCORE SHEET

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

5. Responsibility for Hospital Admissions	1-5	4
6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	1
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.96**	
Highest Possible Score	**5**	