ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 25, 2016

To: Cynthia Jones

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ADHS Fidelity Reviewers

Method

On December 14-15, 2015, Jeni Serrano and TJ Eggsware completed a review of the La Frontera-EMPACT Comunidad 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 Maricopa County.

The Comunidad ACT team was managed through the People of Color Network (PCN), but management transitioned to La Frontera-EMPACT when PCN services ceased at the end of September, 2015. On October 1, 2015, full responsibility of the ACT team, Comunidad, and Capitol clinics were assumed by La Frontera-EMPACT. As a result of the transition, some information typically complied for a fidelity review was not available in its entirety (e.g., staff records could not be formally confirmed through agency human resources). This review focuses on current ACT services through La Frontera-EMPACT, but the timeframe of the review also includes when the team was managed through PCN. Efforts were made by the agency staff to gather complete data for the purposes of the review. La Frontera-EMPACT provides behavioral health services to children, adults, and families. Outpatient and inpatient services are available and include: counseling, psychiatric services, substance abuse treatment, trauma healing, crisis intervention, supportive services, and services for adults with a serious mental illness.

The individuals served through the agency are referred to as "clients" or "participant", 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 daily ACT team meeting on December 14, 2015
- Individual interview with Team Leader/Clinical Coordinator (CC)
- Individual interviews with Rehabilitation Specialist (RS), Substance Abuse Specialist (SAS), and team Psychiatrist
- Group interview with two members
- Charts were reviewed for ten members using the agency's electronic medical records system

- Review of the *ACT Eligibility Screening Tool* developed by the Regional Behavioral Health Authority (RBHA), Notice of Action (NOA) letter, outreach re-engagement and closure protocol, and the Mercy Maricopa integrated care Assertive Community Treatment (ACT) Team Substance Abuse Group Workbook

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 meets five days a week and the team reviews each member at the meeting.
- The team operated at 95% or more of full staffing in past twelve months.
- The Psychiatrist on the team has been on the team since 2008,actively contributes during morning meeting discussions, and works with the team to plan interventions.
- The team consists of ten full time staff for 98 members.
- Based on data provided, during the 12 months reviewed, 95% of the caseload was retained.

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

- The agency needs to evaluate administrative duties and activities of the CC in order to increase community direct service percentage. It is recommended that the CC spend at least 50% of the time providing direct services.
- The ACT team needs to ensure that two full-time Nurses are available for a one hundred member program. The ACT Nurse position is considered a critical ingredient in successful ACT teams. Having two Nurses expands the team's capacity for delivering vital services such as medication administration, health and wellness education, Primary Care Physician (PCP) coordination, and involvement in treatment planning. Some teams elect to assign a small number of members directly to the Nurse, engage Nurses in medication observation, and other aspects of service delivery outside of more traditional nursing functions.
- The team approach should be more integrative: A multidisciplinary group merges their expertise to provide an array of coordinated services necessary to achieve desired goals; however, the demands of teams with "primary caseloads" inhibit specialty staff from performing their role(s) as a primary function on the team. Preferably, the team as a unit will assume responsibility for service provision to members; moreover, specialists should cross-train other team members.
- The team needs to increase their efforts to involve members' identified support systems. It is recommended that the team support and encourage members to identify their informal supports (i.e., people not paid to support members, such as family, landlord, neighbor, friend) and then assist them in acquiring the knowledge, resources and skills needed to support members.

- Services should be delivered primarily in the community and not the office setting; the team should identify what services are currently delivered in the clinic setting that can be provided to members in the community. Treatment groups that address substance use challenges are likely to occur in the clinic setting; the team should review other group activities to evaluate the benefit to members (e.g., Waste Not group) and whether the support can be delivered to members in the community rather than requiring group participation.
- Continue to engage members with substance use challenges to participate in individual and group treatment. The team should implement a recognized integrated dual diagnosis treatment model to standardize the team approach when working with members with substance use challenges. The SAS specialists need formal training to offer effective strategies for treating dually diagnosed members.
- Clarify team expectations regarding face-to-face contact with members to align with fidelity measures. For example, the team demonstrated some understanding of the fidelity item measuring if the team averages four contacts or more for each member, but there is no requirement in fidelity measures that four *different* specialists have contact with each member weekly, though some staff reports this is the expectation.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (4)	At time of review, the team serves 98 members with nine staff who provide direct services (excluding the Psychiatrist) resulting in a member to staff ratio of 11:1.	• Fill vacant positions to adequately provide a high intensity and individualization of services.
H2	Team Approach	1 – 5 (3)	To determine the level of team responsibility for each member, ten member records were sampled for this review. Sixty percent of members reviewed had face-to-face contact with multiple staff, over a two week period. Staff estimate over 80% of members see more than one staff over a two week period.	• Ensure the majority of members have contact with more than one staff over a two-week period, and that all services are documented. Ensure contact is maintained with members who are incarcerated, and outreach is documented for members not in regular contact with the team. • Consider implementing a scheduling system/planning technique that can aid the team in allocating their time and arranging their schedules in ways that will allow members to be supported by multiple staff members (e.g., varying contact by specialty positions, or zone coverage).
H3	Program Meeting	1 – 5 (5)	Per staff report, the team meets five days a week and reviews each member. During the morning meeting observation, the morning meeting started at 9:00 am and ended at 11:30 am, all members were reviewed and Psychiatrist and Nurse were present. Some staff report the meeting usually lasts around two hours, but one staff reported the meeting went longer the day of the review. Staff attributed the extended meeting to the presence of the reviewers and staff providing additional information; since ACT staff is familiar with members they don't usually go into as much detail on a day-to-day basis and as a result the meeting lasts around an hour.	• Review options to streamline the meeting length without sacrificing discussing member status. If ACT team morning meetings are typically two hours long, it will present challenges for the team to provide effective community services.

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H4	Practicing ACT Leader	1 – 5 (2)	The CC of the team reported that she is new to the team as of October 2015; the CC previously worked in the role of Supportive, but was an ACT CC prior to that position. The CC is working on filling the vacancies on her team, getting to know the members, as well as supporting the members and staff with the recent provider change from PCN to La Frontera-EMPACT. Additionally, the CC is working to manage the transfer of twenty-eight new members to the team in October 2015 from another ACT team due to that team having been transitioned to a separate provider outside of PCN or La Frontera-EMPACT. The CC reported that she does not provide direct services in the community as of yet; however, she reported that her priority is building rapport with members and attempting to engage when they come to the clinic for appointments. She also provides services on rare occasions as a backup if needed. A productivity report for the CC was provided, but the document did not reflect actual minutes of services (i.e., reflected service units), and there was no way to confirm actual service minutes per member; member information was not included on the report. There were no direct CC services over a month period documented in ten member records reviewed.	• CC needs to increase direct services to 50% in order to remain in touch with the members served by the team and model appropriate clinical interventions. • The agency needs to review CC's administrative duties and clinic activities and consider if there are any other internal supports who can assist the CC in completing some or all of those tasks seen as barriers to increased direct service to members.
H5	Continuity of Staffing	1 – 5 (3)	Due to the transition of the team from PCN to La Frontera-EMPACT management, complete staffing data over the prior 24 months could not be formally confirmed. Based on available information, the team experienced a 41.7% turnover in two years, with ten staff leaving positions.	• If not in place, the agency should consider using staff satisfaction surveys to determine what is working to retain staff as well as staff exit interviews/surveys to determine what contributes to staff turnover. It is not clear how the transition from PCN to La Frontera-EMPACT impacted staff turnover.

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H6	Staff Capacity	1 – 5 (5)	Due to the transition of the team from PCN to La Frontera-EMPACT management, complete staffing data over the prior 12 months could not be formally confirmed. The CC attempted to gather information for the review through discussion with the prior CC. Based on available information for the prior 12 months, the team operated at 95% or more of full staffing in past twelve months. The team had six total vacancies over the prior twelve month period of review. Currently the team has two vacancies: an Independent Living Skills Specialist (ILS) and second Nurse.	
H7	Psychiatrist on Team	1 – 5 (4)	Psychiatrist on the team has been on the team since 2008. He works four days a week, ten hour days, with Thursday as his day off. During interview, Psychiatrist reported that he attends morning meeting four days a week. He occasionally has to see other members of the clinic, was recently assigned as lead Psychiatrist of the clinic, and has other duties.	• The agency needs to review the Psychiatrist's administrative duties and other clinic coverage responsibilities in order to minimize any activities outside of the ACT team.
H8	Nurse on Team	1 – 5 (3)	The team currently has one full time Nurse. The Nurse works full time, with a schedule of four, ten-hour days a week and Fridays off. The CC reported during interview that the Nurse does attend team morning meetings four days a week but occasionally has to cover other clinic staff and see other members not on the ACT team. The Nurse is not assigned a case load at this time and has minimal contacts in the community.	• Obtain an additional Nurse for the team. A second Nurse could provide additional flexibility for scheduling and improve opportunities to provide health education and care in and outside of the clinic. • Some teams elect to assign a small number of members directly to the Nurse, often those members with chronic or more challenging medical issues. • Some teams elect to include Nurses in medication observation rotation.
H9	Substance Abuse Specialist on Team	1 – 5 (3)	Although the team has two staff in the positions of SAS, only one staff has more than one year of experience. One SAS has been on the team since	• The team should have at least two staff members on the team with at least one year of training or clinical experience in

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			2006 and reports previous work history as a SAS for a substance abuse treatment program, has self-disclosure of lived experience, identifies as a peer, and shares her experience in recovery as appropriate. The other SAS specialist is new to the role and is still in training. The CC reported he holds no past experience or training outside of case management.	substance abuse treatment, per 100 members. • The agency and RHBA should train SAS staff in integrated dual diagnoses treatment; ensure the SAS staff receives supervision to monitor the treatment of adults with co-occurring challenges. Familiarize ACT staff with a stage-wise approach to treatment.
H10	Vocational Specialist on Team	1 – 5 (4)	The team has two full time staff who fill vocational roles on the team: an Employment Specialist (ES) and a Rehabilitation Specialist (RS). Both staff have many years of experience as case managers, but limited formal training in vocational support services (i.e., quarterly trainings through the RBHA). Based on interviews with staff and members, as well as observations of the morning meeting, the vocational staff makes efforts to support member's vocational goals through initial engagement, but due to case management responsibilities, the staff refers out for most vocational services.	• Fully integrated ACT teams include vocational services to assist members to find and keep jobs in integrated work settings. The team should identify potential barriers to directly providing vocational services versus referring to outside providers. • Review training and supervision options to ensure staff identified in the role of Vocational Specialists (i.e., ES and RS) receive support, monitoring, and education in the specific vocational role for the population served.
H11	Program Size	1 – 5 (5)	The team consists of ten full time staff for 98 members. The program is sufficient size to provide necessary staffing coverage.	
O1	Explicit Admission Criteria	1 – 5 (4)	The team did provide reviewers with a copy of the *ACT Eligibility Screening Tool* developed by the RBHA, used to screen potential members for appropriateness for ACT services. Though the ACT population is clearly defined, staff report that members are administratively transferred onto the team from other teams. Although the majority of members were ACT appropriate, the amount of transfers made it more challenging for staff.	• Continue to carefully screen members for ACT appropriateness prior to admission. If members are not appropriate for ACT services, work with referral sources to identify and facilitate admission to a more appropriate level of care whenever possible.
O2	Intake Rate	1 – 5 (1)	For six months prior to the review, the team maintained a low growth rate to maintain stability	• In order to maintain stability of service delivery it is recommended that the highest

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			of service delivery, with the range from two to four admissions per month. However, in September of 2015, twenty-eight members were transferred to the team from another team due to a larger transition of services from PCN to alternative providers when PCN services ceased. The team was at a census of eighty-six, so in order to make room for these transfers, the team had to follow through on some other member transfers and graduations from the team. This transition significantly impacted the monthly average score for this area.	monthly intake rate be no greater than six members a month.
O3	Full Responsibility for Treatment Services	1 – 5 (2)	In addition to case management, the team directly provides psychiatric services and supports. However, the team continues to refer externally for counseling/psychotherapy, substance abuse treatment and employment/rehabilitation services. The members on the team who receive housing support services generally receive the support through the team; however, the team does rely on referrals to staffed residences, with staff reporting more than 10% of members on the team living in staffed residences. Four members were reportedly mandated to live in staffed residences through the Arizona Psychiatric Security Review Board (PSRB).	• The team should request training for any of the service areas they do not feel they are equipped to provide. If other barriers exist to providing the full range of services those issues should be discussed with the agency and the RBHA to find resolutions. • The team currently refers members of the team to the clinic substance abuse counselor for treatment; the team needs to ensure that provider is integrated with the team, attending team meetings and included in treatment decision making. Otherwise, ensure that the SASs on the team are equipped to provide the support. • Prior to the team electing to refer members to staffed residences, consider the services the provider will offer that the ACT team is not expected to provide and how a potential transition of providers (i.e., moving off the ACT team) will impact the member.
O4	Responsibility for Crisis Services	1 – 5 (4)	The team assumes full responsibility for crisis services for members. The team is available to	• The team should provide crisis stabilization services to all members 24 hours a day.

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			serve members 24 hours a day, seven days a week. Staff rotates responsibility for the ACT on-call phone on a weekly basis. CC reported that staff do not answer the phone during the business hours of 8am-5pm,a team staff stationed at the clinic is the "blue dot" coverage for situations that arise. Members report they are not aware of crisis services through the team, do not have the crisis number, and if a crisis occurred, they would contact the crisis line.	Consider having members call the on -call phone 24 hours a day, seven days a week replacing the current blue dot clinic coverage. • The team should ensure members are aware of the 24-hour service through the team, including who to call, and back up contacts through the team. • Ensure members are provided with key phone numbers. At admission, and periodically thereafter, some teams provide a list of all team cell phone numbers for members to use during specific business hours, and an on-call number for after hour calls. Provide education to members regarding the team's role in crisis services.
O5	Responsibility for Hospital Admissions	1 – 5 (3)	The team reports they work with members in an effort to divert from hospitalizations if other support can be provided; they are involved in most hospital admissions. However, some members self-admit or are petitioned and team is not notified until after admission. Per CC interview and data reviewed, staff was involved in four out of the last ten hospital admissions. It is not clear if the addition of approximately 32 total members from another ACT team that transitioned out of the clinic to another provider impacted the ability of the team to be involved in all admissions; the team reports working to build rapport with members.	• Ensure consistent contact is maintained with all members served, which may result in the identification of issues or concerns that could lead to hospitalization. • Continue to build rapport with new members; provide them with team contact information, and on call coverage numbers. Work with each member and their support network to review how the team can support them to potentially divert, or to assist in a hospital admission, if the need should arise.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (4)	Staff reports they are involved in all hospital discharges. Per data reviewed staff was involved in nine out of ten discharges; one member left without discharge planning. Members who recently discharged were discussed in the morning	• Continue to participate in hospital discharge planning meetings as often as possible. • Continue to build rapport with new members; work with each member and

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			meeting. The CC reports staff attempt to see inpatient members every 72 hours, coordinate with inpatient Social Workers and complete applicable applications for services as soon after admission as possible. Once the ACT team and inpatient team agree on a level of care the person needs, the ACT team assists with the steps to get placement.	their support network to review how the team can support them to during discharge. • The team should educate inpatient providers regarding the supports available through an ACT team, such as in-home support services.
O7	Time-unlimited Services	1 – 5 (4)	In the twelve month period reviewed, eight members graduated (i.e., need for services was reduced), and the CC projected another seven for the upcoming 12 months.	• ACT services are designed to be available for as long as the member wants them. Creating arbitrary time limits or transitioning without the member being fully confident in their ability to remain successful can contribute to regression. The team should prioritize retention until the member expresses full confidence in their ability to succeed in a lower level of care.
S1	Community-based Services	1 – 5 (1)	Per ten member records randomly selected for review, the ratio of services delivered in the community verses those delivered in the office ranged from 0-67%, with a median of 15% face-to-face contacts in the community. Three members received no community-based support, and only three members received 50% or more of team contacts in the community. Members reported most contact occurs at the clinic. Documentation of some group activities by certain staff appears to contain the same information for member's week-to-week, and in some cases, from member-to-member.	• The agency and CC need to review staff duties and activities to assure that staff is supported to spend at least 80% of total service time in the community. Work with ACT team staff to brainstorm ideas to increase community-based services. Supportive housing services, assisting with employment goals, peer support services, individual SA treatment, and other skill development activities should occur in the community rather than the clinic whenever possible. • The team Psychiatrist and Nurses should consider increasing community-based services. • Ensure documentation is individualized. • Consider using the on-call phone as the primary contact for staff even during

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				regular business hours rather than relying on a team member "blue-dot" who is office-based. This may aid as the program transitions to provide increased community-based services, allowing staff to be in the field more.
S2	No Drop-out Policy	1 – 5 (5)	Based on data provided, during the 12 months reviewed, two members moved without referral, one cannot be located, and two members refused services; 95% of the caseload was retained. Five members transitioned off the team to a higher level of care, but those members are not included in determining member retention.	
S3	Assertive Engagement Mechanisms	1 – 5 (4)	The ACT team uses a variety of techniques to find members who have lost contact with the team. Staff reported the use of a weekly contact strategy, which includes a checklist of sources that should be contacted while in search of the member (e.g., the morgue, representative payee). Also, the CC provided (a written?) outreach protocol to reviewers. Record review outreach notes appeared to be copied and pasted with the same contents week after week, not matching the checklist protocol. There was also a closure letter sent to a member two weeks into outreach, rather than at the six week timeframe listed on protocol.	• The team needs to make sure that outreach attempts are documented in members' chart as outlined in the agency desktop procedure. • Review documentation expectations with staff, ensure documentation is individualized.
S4	Intensity of Services	1 – 5 (3)	Ten member charts were reviewed to determine the amount of face-to-face service time spent with each member over a month period. The average weekly face-to-face service time was determined for each member. The median service time per member is 50 minutes a week. However, similar to last year's review, many contacts are office-based with three or more staff making contact with some members in the clinic on the same day. Some team	• The CC should periodically review staff notes to ensure activities are documented, accurately reflect the duration of the service, and include services to address member goals and needs. • The team and agency should review the benefit of group activities to members to ensure specific skill building activities occur and are documented.

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			contacts were in group settings where two team staff documented one hour of activity for each member. Some notes had the same content for different members, and some notes had limited information related to actual skill building service. Community contacts include daily medication observation services with the duration of ten minutes (or more), or extended home visits with assessment of the home, but limited content regarding actual interaction with the members.	• The system, RBHA, and agency should collaborate to determine if there are other ways to incent service delivery based on member outcomes. • Ensure documentation is individualized based on member contact. Some medication observation notes appeared to include standard information; full member name was capitalized and appears to be inserted into a template note format.
S5	Frequency of Contact	1 – 5 (2)	The median weekly face-to-face contacts for ten members was 1.75 based on record review. Staff estimates a high frequency of contact with some members, especially those who receive medication observation services.	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member. Ensure outreach occurs for members not in contact with the team, as well as maintaining contact with incarcerated members.
S6	Work with Support System	1 – 5 (1)	The CC reported if a family member or supports are involved, the team has several contacts per week depending on individual's needs. However, based on records reviewed, there was only one contact with informal supports over a month period out of ten records. The contact was initiated by the informal support, and staff feedback focused on educating the informal support about the consequences of the member breaking the law, rather than how the team could engage the informal support to assist the member. Based on morning meeting observation, the team had recent contact with informal support systems for about eight members. Staff report some members do not have informal supports.	• Continue to ensure ACT staff reviews with members the potential benefits of engagement with informal supports, and attempt to secure a Release of Information (ROI) allowing staff to contact identified supports. • If a member declines to allow staff to make contact with informal supports this should be documented in the record. However, staff can generally receive information from informal supports and may be able to share limited data with known supports in some situations. If necessary, review confidentiality guidelines when developing an agency plan to engage informal supports.
S7	Individualized	1 – 5	Staff identified 80 to 84 out of 98 members on the	• The team should directly provide substance

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	Substance Abuse Treatment	(2)	team with co-occurring issues. The SAS's do no direct, individualized substance abuse treatment; however, they are meeting to engage and offer motivational interviewing to three-five members each week. Based on staff report and morning meeting observation, it appears the SAS provides initial engagement, but the team utilizes outside providers or a co-located provider for individualized substance abuse treatment.	abuse treatment, including individual treatment, without relying on referrals to providers that are not integrated into the team. • The team, agency, and RBHA should collaborate to clarify state licensure requirements to provide individual treatment, or if the service can be provided by a non-licensed staff under supervision of a licensed staff.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	At the time of the review the CC reported that for the past two months the two SASs co-facilitated a group weekly that runs on average for an hour. The SAS reports they have facilitated a total of six to eight groups and use the approved group curriculum from the RBHA. However, the SAS reports that they do not have a set schedule for this group because many members from the entire clinic attend the substance group that is offered daily by the licensed co-located counselor for the clinic. The CC and the SAS confirmed that this licensed counselor is not integrated on the team, he does not attend morning meeting, does not provide any updates or feedback upon group attendance, and does not attend staffing's or treatment planning. Approximately five or six ACT members attend group with the ACT team SASs weekly, with about eight members attending at least one group over a month period.	• If not already established, the RBHA should ensure appropriate training and education is provided to ensure the ACT teams are following an established, stage-wise curriculum, such as Integrated Dual Diagnosis Treatment (IDDT). • The team should continue to engage members identified with a co-occurring diagnosis to attend the group offered through the team. Consider establishing a consistent time and location, as well as expanding the number of groups offered through the team and enhancing the curriculum.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	The team reports attempting to use stage-wise approaches; however, there is no documented evidence that the stage-wise approaches are being applied in any formal way. It appears the team is more familiar with a 12-step model (e.g., Alcoholics Anonymous) and focuses on identifying	• Agency needs to provide training to staff in integrated dual diagnosis stage-wise approach to treatment such as IDDT and use this as the standard approach when working with members who have a co-occurring diagnosis; a self-help model

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			triggers, and helping people deal with anger. The SAS reports that she is aware that the model they use is partly confrontational; however, the team support harm reduction with the intention of working toward abstinence with a focus on helping members develop coping skills.	should not be the primary intervention approach. • Provide training and supervision to SAS staff in proven interventions; SAS staff will then be better equipped to cross train other staff.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	The team currently has a full-time, fully integrated, Peer Support Specialist (PSS). The PSS provides member engagement and support services. Members interviewed were not aware of the PSS position or role on the team.	• Consider orienting members to all current team specialists, their roles, what members can expect from the staff and the team, as well as contact numbers for the specialists during their scheduled work hours and the on-call contact number.
Total Score:		3.21		

ACT FIDELITY SCALE SCORE SHEET

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

Responsibility for Hospital Discharge Planning	1-5	4
Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
Community-Based Services	1-5	1
No Drop-out Policy	1-5	5
Assertive Engagement Mechanisms	1-5	4
Intensity of Service	1-5	3
Frequency of Contact	1-5	2
Work with Support System	1-5	1
Individualized Substance Abuse Treatment	1-5	2
Co-occurring Disorders Treatment Groups	1-5	2
Co-occurring Disorders (Dual Disorders) Model	1-5	2
Role of Consumers on Treatment Team	1-5	5
Total Score	3.21	
Highest Possible Score	5	