ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: December 5, 2017

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WICHE Fidelity Reviewers

Method

On October 17-18, 2017, Georgia Harris and Hannah Koch completed a review of the Lifewell Behavioral Wellness 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.

Lifewell Behavioral Wellness (Lifewell) is a multi-faceted, behavioral health service provider for the Regional Behavioral Health Authority (RBHA) of Maricopa County, Arizona. Lifewell's services include outpatient counseling, vocational rehabilitation, residential care, transportation, multiple housing options and Serious Mental Illness (SMI) clinics. Lifewell Behavioral Wellness assumed responsibility of the ACT team from another agency in 2015 and relocated to the new South Mountain clinic in January 2017. At the time or review, the team served 96 members.

The individuals served through the agency are referred to as *clients* and *behavioral health recipients*, 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:

- Observation of a daily ACT team meeting on October 18, 2017.
- Individual interview with the ACT Clinical Coordinator (ACT CC).
- Individual interviews with the Substance Abuse Specialist (SAS), the ACT Specialist (ACT CM) and the Employment Specialist (ES).
- Group interview with two members and an individual interview with one member.
- Charts were reviewed for ten members using the agency's electronic medical records system.
- Review of agency documents such as the *8 Week Outreach Protocol*, the Clinical Coordinator encounter report, *ACT Admission* and *Discharge* Criteria, substance abuse group sign in sheets, ACT *Eligibility Screening Tool*, and training records and resumes for the ES, RS and the SAS.

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 demonstrated a team approach to service delivery. With the use of various internal reporting techniques, staff monitors and ensures that members receive contact from multiple ACT staff over 90% of the time.
- The team demonstrates a well-thought-out engagement strategy and uses street outreach and legal mechanisms when appropriate. The ACT staff shared with reviewers their 8-week outreach strategy, which includes weekly outreach to hospitals, morgues, family, probation officers, and other involved parties.
- In addition to being a fully-integrated ACT staff, the Peer Support Specialist (PSS) specializes in connecting members with opportunities in the community that support their individual recovery goals.

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

- The team experienced more than 150% turnover of staff in the past two years. Though ACT staff report that recent training, shadowing, and team-building efforts by the ACT CC are helpful, overall most staff report experiencing low morale. The agency should study employee satisfaction and seek to improve employee morale through feedback forums and/or other opportunities. These efforts could help generate solutions to perceived workplace hindrances.
- The team was involved in 60% of last ten hospital admissions and 50% of the last ten hospital discharges. In most hospitalization scenarios where the team was not involved, the member had chosen the facility they wanted and was then discharged at will. The ACT team will need to strengthen therapeutic rapport with members. As relationships improve, members may willingly increase their communication with the team in times of crisis. Moreover, improving coordination of care for hospital discharges will require continued outreach and relationship building efforts with the facilities where their members are most frequently admitted.
- Based on the records provided, it was determined that the team provided an average of 46.25 minutes of service per week to each member. In addition to the largely inconsistent reporting of activities such as medication monitoring, staff identified ongoing technology issues that may affect their performance. It would be helpful to address any issues that may prevent staff from entering clinical documentation in a timely and consistent fashion.
- The team variably addresses individualized substance abuse treatment. Though the team has 63 dually-diagnosed members, a total of just three sessions of individual substance abuse treatment were scheduled over the past eight months. Dually diagnosed members should average 24 or more minutes in formal substance abuse treatment per week.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team serves 96 members with ten full-time staff. The member to staff ratio is approximately 10:1. This count excludes the Psychiatrist. At the time of review, the team consisted of ACT Clinical Coordinator (ACT CC), an ACT Specialist (ACT CM), and Independent Living Specialist (ILS), a Rehabilitation Specialist (RS), a Peer Support Specialist (PSS), a Housing Specialist (HS), Substance Abuse Specialist (SAS), an Employment Specialist (ES), and two registered Nurses (RNs).	
H2	Team Approach	1 – 5 5	The team practices a team approach to service delivery. Of the ten records reviewed, it was determined that 90% of the members had face-to-face contact with multiple team members, in a two week period. Staff reported that the team keeps track of member visits through their *seven* and *ten-day* face-to-face reports. Each ACT staff keeps track of their respective schedules on their own calendars; they prioritize emergencies and crisis follow up, with regular face-to-face and specialty visits to follow.	
H3	Program Meeting	1 – 5 5	The team meets regularly to discuss all members of the ACT team. Staff report that the team meets five days a week for one hour. The Wednesday meeting is extended to two hours for the staffing of individual member cases. Though some staff works four, ten-hour shifts, all are expected to attend the Wednesday meeting. Reviewers observed staff providing updates and input on each ACT member during this meeting.	

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H4	Practicing ACT Leader	1 – 5 3	The ACT CC provides routine services to ACT members. The ACT CC reports providing direct services to members and routine in-vivo supervision to staff; however, the balancing of administrative duties and supervisory responsibilities are perceived as significant barriers to increasing her direct services time. Her estimated direct service time was approximately 15%. In the team meeting, the CC was observed providing updates on her individual services provided to ACT members. Reviewers were provided with the CC's face-to-face encounter report. It was unclear from the encounter report provided what the CC's actual minutes of service were; This report listed the members served but did not display the CC's actual minutes of service over the selected timeframe. The CC also reported that the agency's record system was inoperable for just over a week. Reviewers did find evidence of CC direct services in the member chart review, such as Individualized Service Plan (ISP) reviews.	• As a key principle of the ACT model, the ACT team leader should provide direct member services at least 50% of the time. • The agency should work with the ACT CC to identify any administrative duties that may prohibit her ability to provide direct clinical contact to members. • Ensure that the ACT CC's face-to-face encounters with members are consistently recorded in the agency's documentation system.
H5	Continuity of Staffing	1 – 5 1	The ACT team experienced more than 150% turnover in the past two years, with approximately 37 ACT staff leaving the team. Nearly half of the staff listed left in 2016. In the staff turnover tally, it was noted that there were four Psychiatrists and three ACT CCs in that count. ACT staff believed that numerous factors contributed to volume of turnover; most staff expressed difficulty balancing real and/or perceived agency expectations with their ACT responsibilities. Most staff reported low morale, but acknowledged and praised the CC's efforts to improve the confidence and the productivity of the team.	• Consistent staffing is a key ingredient in successful ACT teams. To reduce the potential for increased employee attrition, the clinic and/or agency leadership should solicit feedback from staff on matters affecting employee satisfaction. • As new candidates are being reviewed, consider implementing experiential hiring practices such as job shadowing for potential new ACT team staff, particularly for those job candidates new to the ACT model. • The agency should consider exploring

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				and implementing best practices related to the reduction of employee attrition and improvement of staff morale.
H6	Staff Capacity	1 – 5 4	The team has operated at approximately 88.86% of staffing capacity in the past 12 months. The team was without an RN for five months, a HS for one month and an SAS for ten months. When asked about the challenges in maintaining a fully staffed team, the ACT CC reported that finding staff with professional licenses to fill the SAS position was particularly difficult, as multiple recruits declined the position during salary negotiations.	• To improve recruiting results, the agency should consider assessing barriers to obtaining and maintaining their ideal workforce. In addition to the recommendations made in H5, these analyses could include any efforts to examine competitive salaries and/or budget considerations for the caliber of staff they desire.
H7	Psychiatrist on Team	1 – 5 4	The Psychiatrist works four days a week, with Fridays as her flex day. Staff report having full access to her approximately three days a week. In addition to psychiatric medication and monitoring, staff report that she conducts home visits, coordinates care with PCPs and other external providers. Though staff found her to be attentive to members with scheduled appointments, ACT staff varied considerably in their assessment(s) of her accessibility to both staff and members in need of emergency assistance. Also, most staff stated that she may or may not stay for the duration of the clinical team morning meetings and were inconsistent with their recollection of her attendance frequency; some staff reported that she attends most meetings, but will leave for other appointments, while other staff reported that she "may pop in" occasionally throughout the week, but will not stay for the duration of the meeting.	• ACT teams should have one full-time Psychiatrist for every 100-member team, and should be available for consultation to both staff and members during that time. • If the Psychiatrist is unable to provide necessary consultation due to scheduling discrepancies, the scheduling process should be revisited by the Psychiatrist, ACT team and/or agency.

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H8	Nurse on Team	1 – 5 5	The team currently has two RNs. One RN has been with the team since August 2017, while the other was recently hired in October 2017. Both RNs are full-time employees. Though the new RN is gradually increasing her responsibilities, both RNs are responsible for medications, monitoring of vitals, coordination with Primary Care Physicians (PCPs) and other specialty medical services.	
H9	Substance Abuse Specialist on Team	1 – 5 3	There is currently one full-time Substance Abuse Specialist (SAS) on the team. The SAS has been with the team since March 2017. She has taken college coursework related to substance use disorders and has previously worked on an ACT team for another agency. The SAS stated that she was cross-trained on her previous ACT team to provide Substance Abuse treatment to members. The SAS has also taken Relias trainings for substance use disorders as assigned by the agency and/or the RBHA.	• Continue efforts to recruit and hire an additional, fully-qualified SAS for the ACT team. • Ensure that both SASs receive ongoing supervision and oversight directly related to their specialty.
H10	Vocational Specialist on Team	1 – 5 4	There is currently one Employment Specialist (ES) and one Rehabilitation Specialist (RS) on the team. The ES has worked with the ACT team for over three years in the employment role. Training records presented to the reviewers suggest that the ES has taken Relias training on Supported Employment over the past year. The RS had previously worked with the team for a year as the Housing Specialist (HS). She returned to the team and has been in her current role since July 2017. She has also taken the online Relias new hire and specialty role trainings as assigned by the agency and/or the RBHA.	• Though the team has a sufficient number of vocational staff, the team must ensure that both vocational specialists receive ongoing training and support in the best practices related to their ACT specialties.
H11	Program Size	1 – 5 5	The ACT team has 11 full-time staff and one float staff. The program is of sufficient size to consistently provide necessary ACT services.	

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O1	Explicit Admission Criteria	1 – 5 5	The ACT team has clearly defined ACT admission criteria, as outlined by the RBHA. Potential members are screened by the ACT CC, who is also training the other ACT specialists on conducting screenings. The CC provided reviewers with the *ACT Eligibility Screening Tool* used in the screening process. After screening, the team collectively discusses the member's appropriateness for ACT services with the Psychiatrist prior to program admission. All staff interviewed agreed that there was no administrative pressure to accept members that do not meet the ACT criteria.	
O2	Intake Rate	1 – 5 5	The ACT team reports 9 admissions in the last six months. The ACT CC reported the team's highest intake month was March 2017 with three admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team fully provides psychiatric services, and substance abuse treatment. The team offers both group and infrequent opportunities for individual substance abuse treatment to ACT members. The team does not refer nor has any current attendees at external, outpatient, substance use programs. The team provides Independent Living Skills (ILS) and housing location assistance to members. The Housing Specialist (HS) uses the VI-SPDAT to assess the member's risk level and will apply for housing based on the findings of the assessment tool. Though the team helps members obtain and maintain housing, an estimated 30% of all ACT members reside in places where case management services are offered with varied intensity.	• ACT services should be fully integrated into a single team, with referrals to external providers only for specialty cases, such as court ordered services. • The team should assist members to find housing in the least restricted environments, which can reduce the possibility for overlapping services with other housing providers. • The team should fully assume responsibility for assisting members with the process of finding and maintaining employment in integrated community settings according to the member's preferences. • The agency should explore their options for providing counseling services on the team, either with new or currently

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			The ACT team does not have a staff member assigned to provide counseling or psychotherapy. Members in need of those services are referred to an external agency or the co-located onsite counseling provider at the clinic. The ACT team provides some employment and rehabilitative services. The ES reports working with members on pre-employment activities (e.g. resume building), job development and job retention. The ES also offers a monthly employment group at the clinic. Though the vocational team is working directly with members, some members are referred to external agencies for Work Adjustment Trainings (WAT), enclaves/piecework, and Supported Employment (SE) services.	existing ACT staff.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for its members. Staff considers themselves to be first responders in times of crisis. Staff rotates coverage of their on-call phone every Wednesday. The ACT CC is the secondary backup and is contacted if a decision needs to be made regarding visits to members in crisis.	
O5	Responsibility for Hospital Admissions	1 – 5 3	The ACT team was directly involved in 60% of the ten most recent hospital admissions. Three of the remaining four were self-admissions by the members and the fourth began as a medical admission by ambulance for potential drug overdose. Staff reported that they attempt to coordinate all admissions; however, there are certain members on the team who desire particular accommodations and/or facilities and choose to pursue those options without ACT team involvement. For instance, staff reported that one	• The team should continue to educate members (and their natural supports) on the team's role in crisis and/or hospital admission. As the therapeutic relationship is strengthened, members may increase their communication with the team in times of crisis. • The team should continue to build relationships with the hospitals/inpatient facilities frequented

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			member prefers to receive emergency care from one hospital in particular; his parent will often transport him there and inform the team after he is admitted. Once admitted, the ACT team participates in ongoing treatment coordination with the hospital team.	by members, so coordination of care can be fully achieved.
O6	Responsibility for Hospital Discharge Planning	1 – 5 3	Staff reports that the discharge process begins upon hospital admission. The team coordinates with the inpatient treatment team to establish a discharge plan. Once a member is discharged, the team provides transportation to their residence, and begins their five-day follow up sequence. The ACT team was directly involved in 50% of the most recent hospital discharges. In all of the remaining instances, the ACT team was not notified of the release(s) and members were discharged to the community or to family. In one instance, the hospital released the member to her daughter, whom the guardian explicitly stated that she should not have contact with.	• ACT teams should help to coordinate hospital discharges 95% of the time (or better). • The team should continue to build relationships with the hospitals/inpatient facilities frequented by members, so coordination of care can be fully achieved. • Examine current frequency of member inpatient visits and coordination between ACT staff and hospitals, namely those facilities where ACT members are discharged without warning.
O7	Time-unlimited Services	1 – 5 4	The ACT team reported four graduations over the past year. The team expects to graduate at least six members over the next 12 months. The ACT team gradually reduces contact with members who have lessened their dependence on psychiatric and/or emergency services or may be requesting transition to a lower level of care. If the member identified for transfer begins to increase dependence on the team during the transition period, the team will increase contact and delay the transfer date.	• The team may want to revisit their philosophy regarding transitioning/graduating its members. ACT services are designed to encourage and maintain ongoing, therapeutic relationships indefinitely. Graduation should only occur when members feel they have attained the maximum benefit from the ACT program.
S1	Community-based Services	1 – 5 3	Based on the data provided, it was determined that the ACT team provides more than half of their services in the office. Staff reported that approximately 80% of their face-to-face contacts	• ACT teams should perform 80% or more of their contacts in the community. • For members who are coming into the clinic multiple times a week, the team

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			with members occur in the community. However, the results of the chart review show staff making contact with members in community settings 42% of the time. The chart review also revealed inconsistency in the team's approach to each member. For instance, two members received nearly all their services in the community (including psychiatric appointments), while others received nearly all their services in the clinic.	should explore how to deliver those services in the natural settings where members live.
S2	No Drop-out Policy	1 – 5 4	The team has retained 94.8% of their members in the past 12 months. The ACT CC reports that two of the members declined services and two could not be located. One member was listed as a closure because the team determined the member could not be served. When details regarding the circumstances for closures were requested, the ACT CC stated that the information could not be provided because three of the five closures predated her tenure on the team. None of the closures were identified as members who left the team and moved without receiving relocation assistance from the team.	• Continue all efforts to retain members on the ACT team at a mutually satisfactory level, as maintaining therapeutic rapport can be critical to ongoing service delivery.
S3	Assertive Engagement Mechanisms	1 – 5 5	The team demonstrates a well-thought-out engagement strategy and uses street outreach and legal mechanisms when appropriate. The ACT staff shared with reviewers their 8-week outreach strategy; this strategy includes weekly outreach to hospitals, morgues, family, probation officers, and other involved parties. The team reports that most members are located prior to the end of the eight weeks. If the member is not located within the eight weeks, they are changed to *navigator* status and transferred to a *navigator team* for further outreach. A copy of the outreach checklist was provided to reviewers. Instances reflecting the use of the outreach protocol were also noted in	

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			multiple member charts.	
S4	Intensity of Services	1 – 5 2	Ten member records were reviewed to determine the amount of face-to-face service time spent with each member. The team spends an average of approximately 46.25 minutes per week in total service time per member. The majority showed below average contacts, with only two records reflecting averages above 2 hours of service provision. Staff provided very little insight regarding their challenges in meeting this requirement. However, most staff discussed how their documentation requirements are impacted by ongoing technological issues, such as intermittent access to the agency's electronic health record. In addition, it appeared that staff was largely inconsistent in their noting of relatively standardized activities, such as medication monitoring. Ironically, the length of time most often noted for medication monitoring was either two minutes or 23 minutes.	• ACT teams are required to provide an average of two hours of services, per member, each week. Agency leadership should meet with the ACT team to discuss any barriers that may prevent them from increasing their service intensity. This may include an assessment of available technology, schedules, and staff workloads. • Train staff on appropriate documentation standards so their services can be accurately reflected in the members' medical records.
S5	Frequency of Contact	1 – 5 3	The record review indicated that the team provides an average of 2.25 face-to-face contacts per week, per member. The ACT CC stated that each staff monitors their own visitation schedules through their *Microsoft Office Outlook* calendars. The team's program assistant helps the ACT CC to keep track of member visits through their *seven* and *ten-day* face-to-face reports. Each staff prioritizes visits based on their area of ACT specialty and the immediate needs that arise during the team meetings.	• The ACT team should continue to engage frequently with members, with the goal of averaging four or more contacts per week, per member. • See recommendation in S4 regarding documentation practices.
S6	Work with Support System	1 – 5 4	Staff reported that 50-75% of members have natural supports, but around 35% of those supports are actively involved in their treatment. Staff said they attempt to call all the natural	• Continue to encourage staff to actively pursue informal supports. Also, the team should consider monitoring their documentation of contacts with

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			supports on a weekly basis; those members with out-of-state guardians may receive calls on a monthly basis. The CC also offers a family support group that natural supports are invited to attend. According to the results of the ten-record review, the team averages 2.6 contacts per month with informal supports. The range of family contacts varied greatly in the member records; one record had 22 contacts, two records had one contact and one record had two contacts. The remaining five records had none. The record with 22 contacts in the review period was for a member who received all of her ACT services in-home and was with a family member at each visit.	informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 2	The team provided individualized substance abuse treatment incidentally. The SAS reports that she will review the "stages of change" in an individual session, along with the most recently assigned classwork from the weekly co-occurring treatment group. When asked about the nature of the counseling, the SAS referred to various models, namely, CBT, Matrix model, and Motivational Interviewing. Of the 63 members diagnosed with a co-occurring disorder, three of them received one individual treatment session each over the past eight months. The SAS reports that she plans to extend individual treatment opportunities to additional members in the near future.	• Members diagnosed with a co-occurring disorder should receive an average of 24 minutes (or more) of individualized treatment per week. Their participation in individualized substance use treatment should be monitored. • Ensure that the SASs receive the necessary training, mentoring, and ongoing guidance to provide structured, individual substance use counseling to members identified with a co-occurring disorder. • Continue all efforts to recruit and hire an additional SAS for the ACT program.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team currently offers a one-hour substance abuse treatment group on Wednesdays and Fridays. The SAS reports having four to five people in attendance at each group, per week. The group sign in sheets provided to reviewers suggest six (9%) unique members attended at least one treatment group over a 30-day period. The SAS	• The ACT team should strive to have 50% or more of their dually-diagnosed members engaged in Co-Occurring Disorder (COD) groups on a regular basis. Solicit member enrollment in COD treatment groups; consider involving current participating members

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			stated that they discuss the Stages of Change extensively in their groups. Coping skills, meditation and a feedback session are also incorporated into each group. The SAS will often choose the group topic, but the members occasionally choose the topic of discussion. The groups are open only to ACT members.	with this effort. • Co-occurring treatment groups work best when based in an evidence based practice (EBP) – treatment model. Consider structuring groups around proven curriculum, so group effectiveness/outcomes can be measured.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team uses a mixed model of traditional and stage wise treatment approaches to Dual Disorders treatment. In general, staff were able to discuss the role of harm reduction in DD treatment and nearly every staff was able to articulate the Stages of Change (Di Clemente model). Though most deny the support of abstinence and traditional approaches to DD treatment, most staff confirmed they have received minimal training on the principles of a stage wise treatment approach (i.e. IDDT). Most staff supported the use of medical detoxification solutions for members using heroin, meth, and cocaine. Also, the Individualized Service Plans (ISPs) of the dually-diagnosed members identified in the chart review did not reflect any language, treatment approach, or interventions reflective of a structured, evidence based approach to DD treatment. Most plans were generic in nature, focusing solely on the need for members to "meet with" SAS staff and not the actual interventions used and/or outcomes expected during the ISP period. Staff did not state the use of or direct referral to Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) programs; although, the staff provide moral support to members who choose to attend those programs.	• Train all staff in a stage-wise approach to treatment. • Train staff on how to align treatment interventions to the stages of recovery they have identified. • Train staff on how to incorporate Dual Disorders language and interventions into the member treatment plans.
S10	Role of Consumers	1 – 5	The team employs a full-time, fully-integrated Peer	

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	on Treatment Team	5	Support Specialist. In the team meeting, reviewers observed the PSS as he provided status updates on members and his daily interactions with them. Staff interviewed views the PSS as critical to successful engagement with members. Reviewers also noted frequent interactions between members and the PSS in the member records reviewed.	
Total Score:		**3.75**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1-5	3
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	4
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.75**	
Highest Possible Score	**5**	