# ASSERTIVE COMMUNITY TREATMENT (ACT)
# FIDELITY REPORT

Date: January 29, 2021

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AHCCCS Fidelity Reviewers

## Method

On January 4 - 5, 2021 Annette Robertson and Karen Voyer-Caravona completed a review of the Copa Health Metro Center Varsity Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

The Metro Center Varsity ACT team was managed by Partners in Recovery. Since the last fidelity review, Partners in Recovery merged with Marc Community Resources, Inc. and is now known as Copa Health. Copa Health operates several outpatient centers. Copa Health offers employment related services, day program activities, integrated health, and residential services.

Due to the COVID-19 public health emergency, it was determined that the record portion of the review should be documentation for a period prior to the public health emergency. Reference in this report to the member records reviewed and related documentation are for the period prior to the public health emergency. Due to the public health emergency, the review was conducted remotely, using teleconferencing or phone contact to interview staff and members. Federal, State, and local government guidance regarding contact with others outside individuals' homes has varied per the positivity rates. Some agencies impose their own guidance which may be more restrictive relating to contact with others.

The individuals served through the agency are referred to as *clients* or *members*, 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 an ACT team meeting on January 4, 2021, via video conference.

- Individual interviews with the Team Lead/Clinical Coordinator (CC), Substance Abuse Specialist (SAS), Act Specialist and Peer Support Specialist.
- Individual phone interviews with three members receiving services from the Metro Center Varsity ACT team.
- Copies of documents were reviewed for ten members for a 30-day period prior to the public health emergency.
- Review of documents: Regional Behavioral Health Authority (RBHA) *ACT Admission Criteria*, SAS and VS staff resumes, SAS calendars, and the CC encounter report.

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 5point 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 medical staff positions are fully staffed, including a Psychiatrist, and two Nurses. Medical staff work four ten-hour days.
- The team has a clear admission policy, does not feel pressured to accept inappropriate referrals, and has a slow admission rate.
- Crisis services have continued during the public health emergency. ACT staff meet members in the community when crises arise.
- During the past twelve months the team has had few members leave the team and expect few to leave the team in the next year.
- The team has at least one staff with personal experience of psychiatric recovery. Staff interviewed reported that this staff person does share their story of recovery and that members look up to this person as a role model.

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

- Support the ACT CC to be able to deliver in person services to members 50% of the time. Work to transfer any tasks that can be managed by other staff to allow more time in the community with members and their natural supports.
- High staff turnover can be attributed to many issues; support staff in their specialty roles by providing training and supervision.
- Some specialist positions have been filled by staff with little to no experience in their specialty roles, or in case management of individuals with a serious mental illness. Support staff in their specialty roles by providing training and supervision.
- Staff providing substance use treatment services should be trained and supported to use an evidenced-based approach to substance use treatment as the primary approach, rather as an addendum to other recovery models.
- The team struggles in engaging with and documenting informal/natural supports contacts. Assist members to develop and maintain natural supports to enhance members' recovery, connection to external resources, and integration into their community.

**ACT FIDELITY SCALE**

| Item # | Item | Rating | Rating Rationale | Recommendations |
|---|---|---|---|---|
| H1 | Small Caseload | 1 – 5<br><br>5 | At the time of the review, the team had 11.20 full time equivalent (FTE) staff, not including the psychiatrist or administrative staff, delivering services to a roster of 98 members for a member to staff ratio of approximately 9:1. | |
| H2 | Team Approach | 1 – 5<br><br>4 | Staff reported that 90% of members see more than one staff person in a two-week period. Some staff expressed concern for some members during the public health emergency and their isolation due to fears of contracting the virus. Staff report being assigned a primary caseload of 12 – 13 members for paperwork purposes, but also report being responsible for weekly home visits. Upon review of records from ten randomly selected members, 80% saw more than one staff from the team in a two-week period. | • Optimally 90% or more of members have face-to-face contact with more than one staff in any two-week period. The team approach ensures continuity of care for members and creates a supportive environment for staff. ACT team staff should collaborate on assessments, treatment planning, and day-to-day interventions. Team staff are jointly responsible for making sure each member receives individualized interventions by specialists based on member goals and needs to support recovery from mental illness. |
| H3 | Program Meeting | 1 – 5<br><br>5 | Staff interviews indicate the ACT team meets four days a week, Monday - Thursday, and the Psychiatrist attends all scheduled team meetings via Zoom. The Nurses attend on days they are scheduled to work. During the meeting observed, staff identified their position before updating the team on member issues and activities. Reviewers were informed the ACT Counselor was present at the meeting, however, no introduction was made nor were insights relating to members offered to the team. | • All ACT specialists should provide the team with updates on member contacts, especially those staff that see members infrequently for specialized services. |

| H4 | Practicing ACT Leader | 1 – 5<br><br>3 | The CC estimated providing direct services to members about 30% of the time, delivering medications in the community, completing medication observation, and transporting members. The CC was not working with the team during the record review period. Documentation sent to reviewers regarding actual in-person delivery of services the CC spent with members was 24%. | • Optimally the CC should provide face-to-face services to members 50% or more of the time. ACT leaders that have direct clinical contact with members are better able to model appropriate clinical interventions and remain in touch with the members served by the team. Shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery, are available options.<br>• Explore potential barriers to the CC providing direct services to members of the team. Identify administrative functions that could be performed by the program assistant or by team specialists. |
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| H5 | Continuity of Staffing | 1 – 5<br><br>3 | During the past two years, the team experienced 50% turnover. A total of 18 staff left 13 positions in those 24 months. During this period the team had difficulty retaining staff in the Nursing positions. | • Examine employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention. ACT teams should strive for a turnover rate of less than 20%. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.<br>• When employees leave the team, vet future candidates appropriately to ensure potential hires are prepared for the demands of ACT level of service. |
| H6 | Staff Capacity | 1 – 5<br><br>3 | In the past 12 months, the ACT team operated at approximately 79% of full staffing capacity. Data | • To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions as soon as |

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| | | | provided to reviewers was inconsistent with reports from staff. | possible. Filling vacant positions as soon as possible helps to reduce the potential burden on staff. |
| H7 | Psychiatrist on Team | 1 – 5<br><br>5 | The team has a full time Psychiatrist assigned to work with members on the team. Staff report that although the Psychiatrist does not physically deliver services on site, the Psychiatrist is accessible by phone, text message, or email, including after hours and weekends. Members report to seeing the Psychiatrist through telehealth monthly. Staff facilitate the telehealth appointments in the community and the office. Per the Psychiatrist's request, staff report sitting in with each member during their appointment. | • Ensure member's requests for a private audience with the Psychiatrist are accommodated. |
| H8 | Nurse on Team | 1 – 5<br><br>5 | At the time of the review, the team had two full time Nurses assigned to work with members on the roster. Each Nurse works four ten-hour workdays. Both Nurses joined the team in the recent months before the review. One Nurse has experience working with several of the members from their previous employment at inpatient psychiatric unit. Staff interviewed report the Nurses are available nights and weekends for consultation. | |
| H9 | Substance Abuse Specialist on Team | 1 – 5<br><br>3 | The team has two SASs on the team. One has been working with ACT members for more than three years on the team. The second SAS recently joined the team and has experience working with ACT members, but not in the capacity of an SAS nor do they appear, per the resume provided, to have any experience delivering substance use treatment services. Staff reported that all SASs with this agency receive weekly group supervision. Reviewers requested training records multiple | • ACT is designed for clients that are unsuccessful with traditional case management and require a higher level of service. Ensure the SASs are provided with regular supervision (e.g., weekly) by an experienced substance use clinician that is knowledgeable about the co-occurring model and its relationship to the evidence-based practice of ACT. Empower the SASs as they cross-train the ACT team. |

| | | | times, however, were not considered due the late receipt. | |
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| H10 | Vocational Specialist on Team | 1 – 5<br><br>2 | The team does not have Vocational Specialist (VS) staff with more than one year of experience assisting members diagnosed with a serious mental illness to seek and maintain competitive employment. The Employment Specialist (ES) has experience working with the ACT members in a non-clinical role, but no prior case management experience with individuals with an SMI diagnosis, nor any experience delivering behavioral health services outside of non-clinical administrative support. The Rehabilitation Specialist (RS) joined the team with many qualified years of experience working in the behavioral health field in inpatient units, however, no experience in case management of members with an SMI diagnosis or in delivering rehabilitative services. Training records were requested prior to and during the review process, however, were not received. | • ACT is designed for clients that are unsuccessful with traditional case management and require a higher level of service. Provide training and support to the VS staff in helping members to find and keep jobs in integrated work settings. Optimally, training would include strategies for engaging members to consider employment, job development, supporting individualized job search, and providing follow-along support.<br>• Ensure the new VS staff is provided supervision related to best practices in case management of members diagnosed with an SMI, particularly relating to members with a dual diagnosis. |
| H11 | Program Size | 1 – 5<br><br>5 | The team is adequately sized to deliver a diversity of services to the 98 members on the team roster. | |
| O1 | Explicit Admission Criteria | 1 – 5<br><br>5 | Staff interviewed report following the RBHA admission criteria for new referrals. One staff reported that screenings of new referrals now occur over the phone since staff is not allowed on psychiatric units due to the public health emergency. Occasionally screenings will be done at the clinic after the members completes a health/symptom screening. Prior, the CC and one other staff would complete a screening while the member is still inpatient. If a member is determined appropriate, the Psychiatrist will coordinate care with the referring physician. Staff | |

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| | | | report the Psychiatrist has the final say whether a member is admitted to the team. Currently the team has six individuals waiting to join the team. | |
| O2 | Intake Rate | 1 – 5<br><br>5 | Per data provided to reviewers and discussion with staff, the team appears to have a low intake rate. A total of nine members were admitted to the team during a six-month period. During those months, the highest admission rate was two new members. | |
| O3 | Full Responsibility for Treatment Services | 1 – 5<br><br>4 | In addition to case management, the ACT team is providing psychiatric services, substance abuse treatment services, and counseling services. Though only one record showed a member receiving counseling services off the team, reviewers were informed at least ten members receive services from the ACT Counselor that is assigned to this team. The ACT Counselor is shared with the other agency ACT teams and dedicates about 20% of their time to the Varsity team, including attending at least one team meeting weekly. Sessions are provided through telehealth.<br><br>Full credit for employment services was not given due to data provided, including record review that did not indicate how members are aided in finding and retaining employment. Additionally, the team did not receive credit for housing. More than 10% of members are currently residing in staffed housing, largely congregate style with staff on site that may assist with laundry, meals, prompts for hygiene, and coordinated telehealth appointments with staff. | • Provide ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid members to obtain competitive positions. Focus areas should include job development in the community, aligning the job search with member goals, disclosure, and follow-along supports. Engage and educate members about how the team can directly assist them.<br>• Provide supportive housing services which may include budget development, independent living skills, such that members are able to maintain safe and affordable independent housing.<br>• For those members that reside in staffed residences, determine what independent living options are available where members can be supported by ACT staff, rather than group home managers, or residential staff. Optimally, ACT members reside in integrated housing rather than placement, unless a congregate living setting is the member's preference. |
| O4 | Responsibility for Crisis Services | 1 – 5 | Interviews with staff and members indicate the team provides 24-hour on-call crisis services to | |

| | | 5 | members of the ACT team. Staff report being assigned weekly on-call rotation responsibilities. Interviewees stated that often a phone conversation is all that is needed to provide the support necessary to members, but that they will go into the community if needed. When more than one staff is needed to meet with members, the CC will designate who will accompany the on-call staff. The CC also acts as the back-up to the on-call for the week. Members interviewed were aware of the crisis services available from the team. | |
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| O5 | Responsibility for Hospital Admissions | 1 – 5<br><br>4 | Some data appeared missing and incomplete and could not be clearly accounted for in an interview with staff. Some staff reported that there is a pattern of some members self-admitting, rather than seeking the team's assistance. Staff stated they have encouraged those members to access the services of the team when wanting to seek inpatient services. When a member is assessed as potentially benefiting from inpatient psychiatric treatment, an ACT Nurse will triage the member prior to the Psychiatrist evaluating. If inpatient treatment is recommended, the team will send the member to the nearest psychiatric hospital, or one of their choice, by cab as a measure to reduce risk of spread relating to the public health emergency. Staff follow the member in the cab to the hospital. Staff report urgent-care psychiatric units are still allowing staff to sit with members until they are admitted to the units, however, most psychiatric hospitals do not. In these instances, staff facilitate the admission process by providing up to date psychiatric information, sometimes accessing clinical records on mobile phones to share with inpatient staff. It appears the team was involved in | • Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with more opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build rapport with natural/informal supports that may not be aware of how the ACT team is available to assist. |

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| | | | 80% or less of the ten most recent psychiatric hospitalizations. | |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5<br><br>5 | Staff interviewed report being involved in all of the ten most recent psychiatric hospital discharges. Review of data with staff identified steps the team takes to coordinate care with inpatient staff. Typically, the primary case manager is responsible for coordinating care, but other staff may assist by attending regularly scheduled staffings. When a discharge date is determined, staff meet inpatient staff in an identified location to obtain discharge paperwork and transport the member to the clinic if there are no concerns of transmission of illness. If there are concerns of risk, staff will schedule a cab and follow the cab to the clinic where the member then meets with the Nurse, Psychiatrist and possibly the primary care physician. The team ensures the member has updated medications, transports them (or arranges for a cab) to their residence, and completes five days of in-person visits. It is unclear how or if the follow up visits are tracked. It appears one member was re-admitted during their five day in-person visits from staff. | • Consider tracking team efforts to support members after psychiatric hospital discharges. Some teams do this during the program meeting. |
| O7 | Time-unlimited Services | 1 – 5<br><br>5 | Staff indicate there were six members that graduated from the team in the past year. Staff interviewed report that the team plans to graduate three members in the next twelve months. | |
| S1 | Community-based Services | 1 – 5<br><br>1 | Staff reported that approximately 80% of their in-person contacts with members occur in the community. One member interviewed said nearly all services are received at the clinic, and rarely has staff come to their home. Another member reported having a weekly scheduled visit in the community. Yet, another reported that members | • ACT teams should deliver 80% or more of their contacts in the community where staff can directly assess needs, monitor progress, model behaviors, and assist members use resources in a natural, non-clinical setting. |

| | | | are not allowed to go to the clinic due to the public health emergency, so all contact is in the community. One staff reported that the team still sees members despite the public health emergency but are not to enter members' homes. Instead, staff meet with members outside their door. A review of records prior to the public health emergency showed 17% of staff contact with members occurred in the community. Several records lacked identification of the location of services being delivered. | • For members who are coming into the clinic multiple times a week, the team should explore how to deliver those services in community settings. |
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| S2 | No Drop-out Policy | 1 – 5<br><br>5 | Staff interviews and data provided the reviewers indicate the team has a low dropout rate. Staff reported that one member left the team because they no longer wanted services and one member could not be located. | |
| S3 | Assertive Engagement Mechanisms | 1 – 5<br><br>2 | Staff interviewed reported using an 8-week outreach strategy. The team will meet with members to discuss what services they want or need and to identify barriers to getting those services. Reviewers requested a copy of the engagement policy, but one was not provided. Review of member records from before the public health emergency showed little evidence of assertive engagement strategies. No efforts to engage formal or informal supports were documented in member records. | • Outreach in the community should be a first step. Consider starting outreach efforts immediately after an identified lapse in contact. Discuss who on the team will conduct outreach and what efforts will be made. Track this during the program meeting.<br>• Engaging formal and informal supports is an acceptable form of outreach.<br>• Consider periodic peer review of documentation to ensure outreach efforts are accurately included in member records. |
| S4 | Intensity of Services | 1 – 5<br><br>3 | Per a review of ten randomly selected member records, during a month period prior to the public health emergency, the median amount of time the team spends in-person with members per week is about 61 minutes. Service intensity ranged from an average low of about 14 minutes to an average high of about 223 minutes. The team appeared to | • ACT teams should provide an average of two hours or more of face-to-face 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 |

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| | | | rely on clinic-based groups, other than co-occurring treatment groups. While members were at the clinic, staff often engaged in brief, unscheduled check-ins with members. | week, based on their individual needs, symptoms, and goals.<br>• ACT services were designed to provide a specific combination of services for each member at the frequency and intensity to meet their needs. Focus on delivering community-based contacts that are individualized and geared toward building skills that help the member achieve to his or her unique recovery vision. |
| S5 | Frequency of Contact | 1 – 5<br><br>3 | The median weekly in-person contact for ten members was 2.5 based on review of records prior to the public health emergency. Over a month timeframe, three of the ten members received an average of four or more contacts per week, and four members received an average of less than two contacts per week. During the program meeting observed, staff reported on last contact with members and plans for meeting members in the community. | • ACT members should receive an average of four or more in-person contacts a week. The number of contacts may vary, with some members receiving fewer and others receiving significantly more depending on immediate and emerging needs. The team should continue their effort to contact members in as safe a manner as possible, as community health conditions allow. |
| S6 | Work with Support System | 1 – 5<br><br>1 | Staff interviewed estimated anywhere from 40 - 80% of members having a natural support system. During the meeting observed several staff informed of contact with members' supports, however, review of records showed only one contact with a natural support was documented. | • Increase contacts with informal supports to an average of four per month for each member with a support system. As much as possible, contacts with informal supports should occur during the natural course of providing services to members.<br>• Educate members on the benefits of natural supports and support members in identifying and building those supports. Developing and maintaining community support enhances members' integration and functioning.<br>• Ensure contacts with natural supports are documented in member records. |

| S7 | Individualized Substance Abuse Treatment | 1 – 5<br><br>3 | Per interview with staff, 25 - 30 members with a COD diagnosis receive weekly individual substance use treatment services from either of the two SASs. Staff reported each SAS schedules at least 12 members weekly for individual treatment services and this is tracked on each of the member's calendar. Data provided in interviews and documents reviewed indicate an average of less than 22 minutes across all members with a COD having received individual substance use treatment services. Copies of member calendars were requested, but not received. SAS calendars used to track individual sessions were reviewed and did show 12 members being scheduled weekly between the two SASs for individual substance use treatment services for the month prior to the review. The SASs use the Integrated Dual Disorders Treatment model while incorporating the *Illness Management and Recovery* (IMR) resources. IMR is a psychiatric rehabilitative practice and is not a substance use treatment model. Staff interviewed had a general understanding of the stage wise treatment approach to substance use treatment and referenced a handout on such. Records reviewed, from a period prior to the public health emergency, lacked evidence of the delivery of structured individual substance use treatment services. There was only one documented session of individual services being delivered to a member. One treatment plan noted the member residing in a sober living residence, yet the team did not coordinate care with facility staff. | • Train SAS staff in an evidence-based practice specific to dual disorders treatment such as IDDT model. The use of an evidence-based practice co-occurring treatment model may provide SASs with a foundation from which to draw from when supporting members in their recovery. Some SASs find manuals helpful when learning new concepts. SASs should be able to cross train other ACT specialists on the team in the co-occurring treatment approach.<br>• All ACT staff should engage members with a substance use diagnosis to participate in regularly occurring individual substance use treatment with ACT staff. Across all members with a co-occurring diagnosis, an average of 24 minutes or more of formal structured individual substance use treatment should be provided weekly.<br>• Document when services are offered to members. Even brief interventions relating to substance use, harm reduction practices, or discussions relating to reduction of use, etc., should be documented in member records to allow continuity of care for members. |
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| S8 | Co-occurring Disorder Treatment Groups | 1 – 5<br><br>3 | Staff interviewed report that the team provides members with three different substance use treatment groups. One SAS facilitates two groups | • Provide SAS with ongoing training and mentoring on a co-occurring disorders model, such as IDDT, and in the principles |

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| | | | and the other does the third. Two groups are provided at two different group homes where several members of the ACT team with a COD reside. The third group is delivered at the ACT apartment location. Staff report following the IDDT model, however, report to using Meuser's *Illness Management and Recovery* (IMR) as the curriculum. IMR is not a substance use treatment model, but a recovery model for individuals diagnosed with an SMI. All groups reported to be delivered outdoors and allow for social distancing. However, only members residing in those settings are allowed to attend the groups. The team does not offer a group for members living independently in the community. Staff indicated that members are anxiously waiting for more groups to restart. Staff reported poor attendance during the month before the review.<br><br>Staff estimated 30% of members with a COD attend one substance use treatment group facilitated by ACT staff a month. | of stage-wise approach to interventions, and motivational interviewing. With high turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new, or less experienced staff. Identifying a co-occurring disorder model that the team adheres to can promote continuity in the approach that all ACT specialists can use when supporting members in their recovery.<br>• 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. |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 – 5<br><br>3 | Based on records reviewed and staff interviews the team appears to use a combination of traditional and stage wise treatment approaches to COD treatment. In general, staff were able to discuss the role of harm reduction in dual disorders treatment and nearly every staff was able to articulate the Stages of Change. Though most staff agree that the program does not emphasize abstinence or rely on traditional approaches to substance use treatment, most staff confirmed that abstinence is the ultimate goal for each member. One staff was familiar with the principles of a stage-wise treatment, referencing a | • The responsibility of delivering substance use treatment services to members is the responsibility of the entire ACT team. All staff should engage members with a dual diagnosis in discussions about their recovery goals.<br>• Provide all specialists with ongoing training and mentoring in the principles of the co-occurring model/stage-wise approach. Training should include how to align treatment interventions to the stage of recovery (change) identified, as well as Motivational Interviewing. All staff should |

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| | | | document during the interview, and was able to describe it unscripted. However, documents in the records of members with that co-occurring disorders diagnosis revealed little evidence of recovery-oriented language or interventions that aligned with change stage or appeared designed to move members forward along the readiness continuum. Additionally, there was no evidence of ACT specialists, other than SASs, offering substance use treatment services, either individual or group, to members with a COD. | be working jointly in an effort to move members to the next stage of change using appropriate interventions when opportunities arise. Discuss member's stages in the program meeting periodically to bring awareness to the team as they all work to engage with members around their goals of recovery. *Relias* has many of these trainings available. |
| S10 | Role of Consumers on Treatment Team | 1 – 5<br><br>5 | The team has at least one staff with personal experience of psychiatric recovery. Staff interviewed reported that this staff person does share their story of recovery and that members look up to this person as a role model. Members interviewed reported were aware of a peer on the team. | |
| **Total Score:** | | 105 | | |

**ACT FIDELITY SCALE SCORE SHEET**

| Human Resources | Rating Range | Score (1-5) |
|---|---|---|
| 1. Small Caseload | 1-5 | 5 |
| 2. Team Approach | 1-5 | 4 |
| 3. Program Meeting | 1-5 | 5 |
| 4. Practicing ACT Leader | 1-5 | 3 |
| 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 | 3 |
| 10. Vocational Specialist on Team | 1-5 | 2 |
| 11. Program Size | 1-5 | 5 |
| Organizational Boundaries | Rating Range | Score (1-5) |
| 1. Explicit Admission Criteria | 1-5 | 5 |
| 2. Intake Rate | 1-5 | 5 |
| 3. Full Responsibility for Treatment Services | 1-5 | 4 |
| 4. Responsibility for Crisis Services | 1-5 | 5 |

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