ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

January 19, 2021

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AHCCCS Fidelity Reviewers

Method

On December 14 and 15, 2020, Karen Voyer-Caravona and Annette Robertson completed a review of the Southwest Network Northern Star 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.

Southwest Network offers behavioral health services to infants, children, adolescents and adults. Adults are served through four service sites, one of which is the Northern Star location. The Northern Star ACT team is one of three ACT teams operated by the agency. When the team was last reviewed in 2018/2019, the team operated at a different location and was known as Osborne ACT. The team relocated in the last year to its current location on Royal Palm Road in Phoenix, to no apparent or reported disruptions in caseload or staffing.

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 video or phone contact to interview staff and members.

The individuals served through the agency are referred to as "members" or "clients"; 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 ACT team meeting on December 14, 2020 via video-conference;
- Individual interview with the Team Leader/Clinical Coordinator (CC);

- Individual interviews with Substance Abuse Specialist (SAS), Employment Specialist (ES), and Rehabilitation Specialist (RS);
- Copies of service plans and thirty days of clinical documentation for the 30-day period prior to the public health emergency were reviewed for ten members; and,
- Review of documents: the agency *Lack of Contact Checklist* and *Lack of Engagement* policy, resumes and training records for the SASs and vocational staff, the CC encounter report, substance use treatment resources, and substance use treatment group sign-in sheets.

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 ACT team is fully staffed, with diversity of specialty staff, to meet the needs of the 100 member ACT team. Most of the ACT team staff have been in their positions for greater than two years, including the CC and the Psychiatrist. Identify factors that contributed to good staff retention; insights may prove valuable for other teams within the system and ultimately strengthen member care.
- The Substance Abuse Specialists and vocational staff all have over two years' experience on the team in their positions and have received relevant training specific to their specialty areas. It is recommended that the agency continue to support staff professional development in their specialty area.
- The ACT team has retained over 95% of membership in the last 12 months, with a low drop-out rate.

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

- The CC should deliver face-to-face services to members 50% of the time. Service time can include hospital visits, meeting with members and their natural supports, crisis response, and mentoring specialists during visits to members' homes. The agency and the team should identify any responsibilities that could be reassigned to other staff to free up the CC's time to increase delivery of direct member services.
- As public health conditions improve, evaluate how the team can support members who receive a lower intensity and frequency of service. Under typical circumstances, the ACT team should provide members an average of four or more face-to-face contacts, and two hours or more of face-to-face contact weekly. In sample records, over a month period (before the public health restrictions), some members received infrequent contact, lapses in contact or outreach. Ideally, services are individualized and primarily community-based. The ability of staff to perform certain community-based contacts may be impacted by changing public health guidance.

- Ideally, 50% or more of members with the co-occurring disorders diagnosis should participate in a co-occurring group. Staff may benefit from training on strategies to engage members in group substance use treatment. Evaluate the substance use treatment groups to ensure the focus on members with co-occurring diagnoses. Consider developing substance use groups that are specific to member's readiness or stage of change and make referrals accordingly.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The 100 member ACT team is served by 11 staff (excluding the ACT Psychiatrist) for a member/staff ration of 9:1.	
H2	Team Approach	1 – 5 4	Eighty percent (80%) of ACT members had face-to-face contact with more than one staff in a two-week period. Staff contacts are reported and recorded on a tracking form during the treatment team meeting. Since the public health emergency more contacts occur via phone or by video conference. Staff and members interviewed said the team has continued meeting with members face-to-face by practicing social distancing, meeting outside whenever possible, and using masks and other recommended personal protective equipment (PPE).	• Increase face-to-face contacts members have with more than one staff in a two-week period to 90% or more.
H3	Program Meeting	1 – 5 5	The ACT team meets four times weekly for treatment team meetings on Monday, Tuesday, Thursday and Friday. Wednesday is dedicated to meeting with members in the community. The Psychiatrist is present at treatment team meetings. At the meeting observed remotely by the reviewers all members were discussed. The meeting was led by the CC. Specialists reported on their contacts with members, identifying their stage of change, needs, functional status such as living situation and employment, and action plans. The Psychiatrist reported on recent appointments with members, medication changes, observations, and recommendations.	

H4	Practicing ACT Leader	1 – 5 3	Staff reported that the CC provides direct service to ACT members but that travel time challenges the goal of direct service delivery 50% of the time. Based on staff interviews and a review of ten randomly selected member records, the CC provides direct member services routinely as backup. Evidence of CC contacts with members was found in the record review, most of which lasted for 20 – 25 minutes. The CC also reported face-to-face contact with members during the team meeting. Some members interviewed reported face-to-face contact with the CC during the week before the review.	• Under ideal circumstances, the CC's delivery of direct services to members should account for at least 50% of the time. • Identify administrative tasks currently performed by the CC that can be transitioned to administrative or support staff, if applicable.
H5	Continuity of Staffing	1 – 5 4	The ACT team experienced 25% staff attrition staff in a 24-month period. Six staff left the team during that period, five of whom were in the nursing position. Most ACT staff have been with the team for at least two years.	• Attempt to identify factors that contributed to staff turnover or support retention. Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their supports.
H6	Staff Capacity	1 – 5 5	For the 12-month period before the review, the ACT team functioned at 98% capacity. Two nurses left the team during the period under review; the positions were filled the following month. One staff member passed away during the review period; the position was filled the next month.	
H7	Psychiatrist on Team	1 – 5 5	The ACT team has one full-time Psychiatrist for 100 members served. The Psychiatrist is well-regarded by staff and members interviewed. Staff described the Psychiatrist as easily accessible by phone, text, email, including after business hours and on weekends. Staff said that the Psychiatrist conducts home visits, and evidence of this was found in the record review**.** Since the public health emergency, the Psychiatrist met with members by virtual means at their homes. Some	

			members interviewed reported seeing the Psychiatrist monthly via video conference from their home and finding it convenient.	
H8	Nurse on Team	1 – 5 5	The ACT team has two full-time Nurses for the 100 members served. The Nurses work four, ten-hour days and attend treatment team meetings on their scheduled days unless occupied with direct member care. Evidence in the record review showed the Nurses conducting home visits to deliver injections and medications, conduct labs, and making follow up outreach after missed appointments. Staff described the Nurses coordinating care with primary care physicians (PCP) for physical health needs, as well as providing health and wellness education.	
H9	Substance Abuse Specialist on Team	1 – 5 5	Both SAS have been in the role for more than two years. Training records provided the reviewers show that the SASs received agency and Relias trainings over the last three years in substance use disorders treatment, co-occurring disorders treatment, and motivational interviewing.	• Ensure ongoing training and clinical oversight to support the specialty position.
H10	Vocational Specialist on Team	1 – 5 5	The ACT team has two full-time vocational staff with more than two years' experience on the team as the ES and the RS. Both have received recent agency and Relias trainings (i.e., Supported Employment, disability benefits, and motivational interviewing) to support their roles assisting members in finding competitive employment and to support psychiatric rehabilitation goals.	• Ensure ongoing training and clinical oversight to support the specialty position.
H11	Program Size	1 – 5 5	The ACT team is fully staffed, with a team of 12, including the Psychiatrist, serving 100 members. The team has the diversity of staffing to support all members' behavioral health needs, although it may not be fully leveraged (see Item O3, Full Responsibility for Treatment Services).	

O1	Explicit Admission Criteria	1 – 5 5	Staff interviewed described explicit admission criteria that has been developed by the agency and the Regional Behavioral Health Authority which focuses on voluntary services for Seriously Mentally Ill determined adults who are high users of emergency and inpatient psychiatric services. The CC screens referrals. Though participation on the ACT team is voluntary, services are offered to eligible members three times and discontinued if rejected. The CC staffs interested referrals with the rest of the team before an intake is scheduled. Staff interviewed reported no external pressure to accept referrals. Referrals come internally from other ACT teams or supportive level teams, from inpatient and corrections settings, and the RBHA. The team does not recruit, and at the time of review, had a waitlist of five members. Before the public health emergency, intakes were done in person, including at inpatient settings. Since the declaration of the public health emergency, intakes are done over the phone, including for those referrals at inpatient and corrections settings.	
O2	Intake Rate	1 – 5 5	The ACT team reported an intake rate well within the range for each of the six months before the review. The team reported zero intakes for June and November; one intake each for July, September, and October; and three for August.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team was given credit for full responsibility for three out of five services: psychiatric care, substance use treatment, and employment and rehabilitative services.	• Ensure future staffing includes person with qualification to provide counseling/psychotherapy on the team. • Consider providing clinical oversight to support provision of counseling psychotherapy on the team. Clinical supervision that supports post-Master's

			The reviewers could not give full credit for housing, with 10% or more of members in staffed or semi-staffed settings where some level of service may be provided, including halfway houses, homeless shelter, and community living placement with a one-to-one. No credit could be given for counseling/psychotherapy due to reported lack of qualified staff; approximately three members have been referred to outside providers. However, one SAS has a Master of Counseling Psychology and another staff is pursuing the same degree. Both staff could provide the service under appropriate clinical oversight.	degree credentialing may further incentivize staff retention. • Continue to track the number of members in staffed residences. As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team. Optimally, fewer than 10% of ACT members are in settings where other social service staff provides support.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides crisis services to members 24 hours a day, seven days a week. On-call responsibility rotates weekly among specialists, with the CC acting as backup. Despite the declared public health emergency, the ACT team has continued to offer onsite response when necessary using public health guidance to reduce risk to both members and staff. Members interviewed were aware the team provided crisis services, describing how to access the on-call and individual specialists with contact information provided by the team. Staff said that printed contact information for all staff and the on-call number is given to members at intake and regularly during home visits. Staff also said that they program contact information into members' mobile phones, and this was confirmed by several members interviewed. Some members said they have used the on-call line. Staff reported the crisis line typically diverts calls received from members back to the ACT team.	

O5	Responsibility for Hospital Admissions	1 – 5 4	Staff interviewed reported that the team seeks to divert members from psychiatric hospitalization via team response community-based interventions that promote use of coping skills, problem solving, effective behaviors, and natural supports. Per a review with the CC of the most recent inpatient psychiatric admissions, the ACT team had direct involvement with 90% of the last ten. One member self-admitted to inpatient after determining the need for detoxification treatment; staff noted the facility contacted the team the next day and that the individual has insight into needs and supported the decision. Although another member was taken to an inpatient facility by law enforcement, the team was filing an amendment to the court ordered treatment (COT) at the time, and thus was given credit for direct team involvement. Three members were admitted following the team filing amendments to COT. One member was taken to an inpatient facility with physical and psychiatric symptoms and admitted, and then later readmitted when ACT staff assessed original symptoms had not resolved after discharged. The team coordinated one hospitalization when a member showed increased symptoms due to medication noncompliance. Another member was hospitalized when showing escalating symptoms during a home visit by an ACT Nurse, who contacted law enforcement for transport. Staff reported some changes in protocol since the public health emergency; they continue to transport members for inpatient admissions, following public health guidance, and remain with members to facilitate admission at most hospitals. They are not allowed to accompany them to units	• Maintain regular contact with all members and their support networks (both informal/natural and formal). This may result in earlier identification of issues or concerns relating to members, allowing the team to offer additional supports, which may reduce the need for hospitalization. Develop plans with members in advance, especially if they have a history of hospitalization without seeking team support.

			since the public health emergency nor can they have in person contact with the member while they are hospitalized. Staff said that at the time of admission they attempt to make contact with the inpatient social worker to share information and begin coordination of care; subsequent staffings, doctor-to-doctors communication, and discharge planning is done by phone. Likewise, contacts with members who are inpatient still are supposed to occur every 72 hours but are done by phone. Staff said hospitals do not allow use of video conference.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	A review of the most recent inpatient psychiatric discharges with the CC indicated that the ACT team was responsible for 100% of the last ten. The reviewers were told that the team begins discharge planning at the time of the admission or as soon as they become aware of an inpatient admission, coordinating with inpatient staff such as social workers, nurses, and doctors, providing medication sheets, coordinating for discharge staffings, and doctor-to-doctor communication. Since the public health emergency, discharge planning with inpatient staff occurs by email or phone. Unless arranged otherwise, the ACT team transports the member home (or wherever they will be staying) upon discharge, arranging for a follow up appointment with the ACT psychiatrist in the first 72 hours, ensuring the member has necessities in place where they will be staying, and filling prescriptions. The team rotates two to three staff to conduct five-day face-to-face contacts to ensure thorough assessment of post-discharge functioning.	

O7	Time-unlimited Services	1 – 5 5	Since the last review, the team reported no graduations and expects to graduate less than five percent of members in the next 12 months. Graduation is discussed with members who request it or are deemed sufficiently stable in the community and not using intensive services. Staff interviewed stated that ACT may itself be the source of stability and wish to avoid withdrawing critical support. Staff thus prepare members for what to expect from supportive level case management, reducing service intensity over a 30-day period. Members are not compelled to graduate.	
S1	Community-based Services	1 – 5 3	A review of ten randomly selected records (from before the public health emergency) show that the team averaged 52% of contacts in community-based settings, including home, PCP appointments, and retail settings. The delivery rate of community-based services ranged from an average low of zero (n=3) to an average high of 100% (n=2). Some records showed members spending an hour or more in clinic-based groups other than co-occurring groups. At the time of the review, the team was not providing groups in the clinic due to the public health emergency but instead holding them in community locations where social distancing could be practiced.	• Under optimal circumstances, 80% or more of services occur in members' communities. As public health conditions improve, evaluate how the team can increase the frequency that services are delivered to members in the community. • Other than co-occurring groups, skill building and other support provided individually should occur in the community setting where challenges and new learning are the most likely to occur.
S2	No Drop-out Policy	1 – 5 5	During the period under review, the ACT team retained more than 95% of members. One member and their guardian left the geographic area and rejected staff attempts to provide a referral for services in the new location. Another member was discharged off the team to avoid duplication of services after moving into 24-hour residential services. Four members passed away during the 12-month period, and two members	

			transitioned to the Arizona Long-Term Care System (ALTCS).	
S3	Assertive Engagement Mechanisms	1 – 5 4	Per the agency's *Lack of Engagement Desktop Procedure* when ACT members who have been out of contact, or not using or engaging in services, staff must make "attempts to re-engage the member for a minimum of eight weeks, with four outreach attempts per week and more intensive outreach if clinically indicated." Two of the four weekly outreach attempts should be conducted in the community and include street outreach. The team uses an agency created *Lack of Contact Checklist* that shows outreach tasks for eight weeks, extending to 12 weeks for high-risk members. Staff said they generally outreach "as long as it takes" to make contact and that most people turn up. Outreach tasks include phone calls and letters to the members, searching areas known to frequent, contact with natural supports, payees, probation officers, shelters, and the morgue. Staff said that one person is currently on outreach. No staff was able to identify having discharged any one from the team due to lack of engagement. The record review revealed some indication that outreach may not be consistently documented. Evidence of outreach of a week or more was lacking in some records after missed appointments or events such as eviction. Though one record showed contact between a jailed member's parent and the ACT team, the record also contained no documented outreach efforts for over ten days to engage the member while in jail. A subsequent progress note did show a subsequent attempt by staff to visit the member while in jail, which was declined by the member.	• The ACT team should follow established outreach strategy; identify and find solutions to barriers to carrying out outreach efforts. • Ensure all outreach efforts, including letters, phone calls, and contact with formal and natural supports are documented in member records.

S4	Intensity of Services	1 – 5 2	Member records sampled showed that members received an average of 48.5 minutes of staff contact in a week period reviewed, prior to the public health emergency. Service intensity ranged from zero to 584 minutes. One record showed zero minutes for a member who was on outreach and then in jail. The high range was primarily due to participation in groups, many of which were groups other than co-occurring disorders treatment groups. Staff said that since the declaration of the public health emergency, groups are no longer held in the clinic. Staff said that although they continue to provide face-to-face engagement, more contacts are by phone or over platforms such as Zoom. Staff reported looking forward to again meeting with members regularly face-to-face but described that current conditions as presenting opportunities for members to learn technical skills increasingly required in a world already reliant on technology. Members interviewed reported staff have assisted them in setting up and using computer and cellular technology to interact with the team.	• As public health conditions improve, evaluate how the team can support members who receive a lower intensity of service. Under typical circumstances, the ACT team should provide members an average of two hours of face-to-face contact weekly. • With the exception of co-occurring groups, emphasize delivery of individualized, community-based services. • Staff should continue efforts to have contact with members who are in corrections facilities for support and to maintain connection to the team.
S5	Frequency of Contact	1 – 5 2	Per the record review, ACT members had an average of two contacts with staff in a week period. Frequency of contacts ranged from zero contacts on the low end to a high of 7.75 contacts. The member with zero contact was in jail most of the 30-days reviewed, while the member with the highest average weekly contacts received most of those in clinic or community-based groups. One record showed a member who had recently been evicted averaging one weekly contact only when coming to the clinic to refill medication or see the	• The team should continue their effort to contact members in as safe a manner as possible, as public health conditions allow. Optimally, ACT members receive an average of four or more face-to-face contacts a week. The number of contacts may vary, with some members receiving fewer and others receiving more contact depending on immediate and emerging needs.

			Psychiatrist; efforts to engage in the community were not documented.	• See recommendations for S4, Intensity of Services.
S6	Work with Support System	1 – 5 2	Per the record review, staff contact with members' natural supports averaged 0.80 contacts per month. Some records showed contacts occurring during in person home visits or by phone during outreach to locate members who were out of contact. Some members interviewed reported having natural supports and were aware that staff sometimes spoke with them. Other members indicated they either did not have a natural support or did not want them to be involved in their treatment.	• Continue efforts to engage members' informal support systems as key contributors to the member's recovery team. Staff may be able to model recovery language and provide tips to family members and other natural supports on how they can support member treatment. • Regularly review member records to confirm that informal support contacts, including emails and phone calls, are documented as well as updated releases of information.
S7	Individualized Substance Abuse Treatment	1 – 5 4	The reviewers were told that approximately half (38) of the 76 members identified with a co-occurring disorder, receive 30 minutes of structured, individual substance use treatment weekly. Most sessions occur in member homes or in the community. Staff said that sessions are structured around SAMHSA worksheets, Integrated Dual Disorders Treatment, Harm Reduction, motivational strategies, and skill building. Between five to ten members receive an extra 30 minutes, usually those in the pre-contemplative stage of change. Sessions are tracked in the treatment team meeting, and this was observed in the meeting attended remotely by the reviewers. Though requested, the reviewers were not provided calendars showing sessions completed for the review period. Records showed that less than half of the members identified with a COD received one or more episodes of individual substance sure treatment. Across the team, it was calculated that members identified with the co-occurring diagnosis receive	• Provide an average of 24 minutes or more of individualized substance use treatment for members with the co-occurring diagnosis. • Train staff on strategies to engage members in individualized treatment as appropriate, based on their stage of treatment. Make available ongoing supervision by the SASs or other qualified staff to support the SASs' efforts to provide individual substance use treatment.

			less than 24 minutes of individual formal substance use counseling.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The ACT team currently offers three co-occurring groups to members with a co-occurring disorder. Currently, and before the public health emergency, two of the in-person groups are held in the community. Staff said that group attendance before the public health emergency was approximately eight – 15 members, with ten attending consistently. Since the public health emergency, four to ten members attend, with four consistently attending. The in-person community-based groups are held outside, at a social distance. A third group is held over the phone for those members who are not comfortable meeting in person. The reviewers were told that the groups follow DiClemente's *Group Treatment for Substance Abuse: A Stages of Change Therapy Manual*. One group, COPE or *Creating Opportunities Off Positive Encounters*, is held at an area park and is geared towards engaging men in substance use treatment through socialization and includes recreational activities to alleviate boredom and encourage rapport and trust between members. The SAS who facilitates this, structured the group around personal research in substance use treatment. Staff reported it is not closed to members without a COD diagnosis because some members are recovering from other addictions. Staff reported attendance to this group has increased from attendance levels before the public health emergency declaration. The other SAS leads the second and third groups. The second group is focused on skill building, held outside of the ACT house, and only open to members with the COD diagnosis. A third phone-in group, also a	• The team should continue their efforts to engage members in group substance use treatment, in as safe a manner as possible, as community health conditions allow. The SASs should continue to collaborate with other specialists to engage members in co-occurring group participation with the goal of at least 50% of members with co-occurring diagnoses. • Co-occurring groups should be offered exclusively to individuals identified with a co-occurring alcohol or substance use disorder. Admitting members without the co-occurring diagnosis can result in straying from the intended focus on complexities associated with co-occurring disorders.

			skill building group, is exclusive to members identified with a COD. Based on a review of co-occurring treatment group sign-in sheets provided to the reviewers for the month of November, 22% of members with a COD attended at least one co-occurring group. Evidence of group attendance in member records showed that approximately 1/3 of members attended at least one co-occurring group during that period, before the declared public health emergency.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The ACT team appears to be primarily following the dual disorders model. Staff interviewed and observed in the treatment team meeting demonstrated knowledge of the stages of change. Familiarity with the stage wise treatment approach was not evenly distributed across all staff interviewed. The team does not appear to refer to AA/NA but will support members who wish to use this community support. Detoxification referrals were described as limited to situations of medical necessity, mainly associated with alcohol withdrawal. The team appears to focus on harm reduction rather than abstinence but may benefit from an expanded understanding of harm reduction beyond reducing use or choosing less lethal means. Some references to sobriety and abstinence were noted in service plans but it is unclear if this was a reflection of the member's voice or clinical jargon.	• Provide ongoing guidance to all staff in a stage-wise approach to treatment, including how engagement, persuasion, active treatment, and relapse prevention can enhance their use of the stages of change model. Discuss with staff how interventions align with a member's stage of change and treatment, and how to reflect that treatment language when documenting the service. Stage wise treatment and intervention is an important element of IDDT.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has at least one staff member with lived experience of recovery from SMI. Staff interviewed said the staff members uses their lived experience of recovery to support and encourage members and to provide other staff with the peer perspective. Most members	

			interviewed were aware that there was a peer on the team and described peer support as valuable.	
Total Score:		4.21		

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	4
6. Staff Capacity	1-5	5
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	5
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5

	Rating Range	Score (1-5)
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	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	4.21	
Highest Possible Score	**5**	