ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: March 2, 2022

To: Amy Viets, Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On December 14 – 15, 2021, Annette Robertson, and Jasmine Davis completed a review of the Copa Health Metro Omega Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback on 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 Omega ACT team was previously 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.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. Delivery of telehealth services, including phone only, were calculated for this review, however those totals are not included in calculating scores for those items that measure in-person contact between the ACT team and members. This review was conducted remotely, using video or telephone to interview staff and members.

The individuals served through the agency are referred to as clients or participants, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

During the fidelity review, reviewers participated in the following activities:

- Remote observation of an ACT team meeting on December 14, 2021.
- Individual interview with the Clinical Coordinator.
- Individual interviews with the Substance Abuse, Housing, Employment, Peer Support, ACT, and Rehabilitation Specialist.

- Individual phone interviews with three members participating in ACT services with the team.
- Charts were reviewed for ten members using the agency's electronic medical records system.
- Review of documents: *Mercy Care ACT Admission Criteria*, NATURAL SUPPORT TRACKER, *Contact and Fidelity Guidelines ACT*, *Omega ACT Team Staff Contact*, CC Productivity, resumes and training of SAS and VS staff, and substance use resources.

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 CC provides direct services to members at a high rate, likely providing valuable insight into member needs.
- There are two Nurses on the team to deliver integrated care to members, are accessible to the team, and deliver services in the community.
- The ACT team has continued to provide members crisis services in the community despite the public health emergency.
- The Omega ACT team has a low dropout rate from the program with only two members in the past 12 months moving off the team due to lack of engagement.
- The team has more than one staff with lived psychiatric experience on the team and at least two share their story of recovery with members.

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

- Increase in-person contact with members by diverse staff. Although this team has an appropriate member to staff ratio, a team approach is not utilized. This limits members' exposure to the specializations of staff and individualization of services. The core of an ACT team is to approach member care by the entire team, reducing potential burden on staff of the responsibility to deliver all the services to those members specifically assigned.
- ACT teams should meet at a minimum of four times every week to briefly discuss every member and the Psychiatrist should attend at least one program meeting weekly.
- Increase community interactions with members. Agency policy has limited the ACT teams' ability to provide in-person services to members. Increased intensity and frequency of contacts should be provided to members at their individualized and expressed need, not an agency determined number. Use of technology may provide a means to increase contact and support, however in-person is the preferred method of assessing and supporting member needs in the community.
- Documentation of services should be entered into member health records shortly after delivery of those services.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, there were 10 full time equivalent (FTE) staff on the team, excluding the Psychiatrist and program assistant. It was reported that there are 98 members on the team, leaving a member to staff ratio of approximately 10:1. A counselor is assigned to the team 20%, however only attends the treatment team meeting once a week so is not considered a member of the team.	
H2	Team Approach	1 - 5 2	Staff reported that the agency has implemented a restrictive in-person contact policy due to the public health emergency. At one point, the team was only allowed to have contact with members once a week. It was reported by one staff that the policy loosened up just weeks before the fidelity review. Another staff reported it loosened up in late September. Reviewers were informed that ACT staff are now limited to two in-person contacts a week with each member. Staff stated that 10 – 12 members are assigned to each and that members are seen twice a week with one of those visits being at the member's home. Of ten randomly selected member records reviewed for a month period, 30% received in-person contact from more than one member of the team in a two-week period.	• Increase in-person contact with members by diverse staff. Under ideal circumstances, 90% of ACT members have contact with more than one staff in a two-week period. Consider options to increase in-person contact while following public health guidelines. • The team approach ensures continuity of care for clients and creates a supportive environment for staff, potentially reducing burden of responsibility. Staff should be cross trained to work as a *transdisciplinary* team rather than individual case managers. ACT team members should collaborate on assessments, treatment planning, and day-to-day interventions.
H3	Program Meeting	1 – 5	Reviewers were provided conflicting information regarding the frequency of program meetings for	• ACT teams should meet at a minimum of four times a week to briefly discuss

		2	the ACT team. In the meeting observed by reviewers via videoconference, staff appeared to have been especially prepared. Reviewers were informed that the meeting had been practiced in advance. Staff reports about the frequency of the program meeting varied from once a month to the team trying to meet four times a week. The team meets in person to review all members of the team but will occasionally meet via teleconference. Reviewers were informed that a Nurse not present for the meeting was in the community assisting a member to connect with a specialty provider.	member status, problem solve interventions and assignments to address and reduce future crises, and review and plan rehabilitative services for each client. • The Psychiatrist should attend the full duration of the team meeting at least once per week.
H4	Practicing ACT Leader	1 - 5 5	The CC estimates spending 75 – 80% of their time in direct service with members of the ACT team. The CC reports assisting with medication observations, crisis calls, home visits, and outreach efforts. Documentation of productivity for a month period showed an average of approximately 22 hours of direct in-person services being delivered weekly to members of the ACT team by the CC. The CC provided 14 visits to members in their home during the month period of records reviewed. No videoconferencing services were delivered and under an hour of phone contact was provided to members. *The fidelity tool does not accommodate delivery of telehealth services.*	• Agency and system stakeholders may want to consider evaluating the practices of this team leader and the ability to provide direct services to members while also leading this ACT team. Members and staff benefit when CCs are highly engaged in delivery of direct services to members.
H5	Continuity of Staffing	1 – 5 4	Based on information provided, the team experienced turnover of 27% during the past two years. At least seven staff left the team during this period. The Nursing positions had the highest turnover. Two members interviewed expressed concern about the high turnover of staff on the team	• Continue efforts to recruit and retain experienced staff. Attempt to identify causes for employee turnover. Optimally, turnover should be no greater than 20% over a two-year period. Ensure staff receive training and guidance applicable to their specialty position.

H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team operated at approximately 90% of full staffing capacity. The second SAS, the ILS and HS positions were vacant for multiple months. One staff was on leave for more than one month.	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible. Timely filling of vacant positions also helps to reduce the potential burden on staff.
H7	Psychiatrist on Team	1 – 5 5	Staff report the team has one FTE assigned Psychiatrist that is available to the team after hours and weekends. In-person visits are currently being limited to essential visits only per agency policy. By utilizing telehealth services, the Psychiatrist is flexible to member needs when concerned about meeting in-person. The team will assist in facilitating telehealth appointments when members are comfortable with staff in the home. When members are on site for nursing appointments, the Psychiatrist is said to see members as well through use of telehealth. When members are seen in-person, the team will conduct a screening to assess risk. Staff report the psychiatrist is supposed to see members every 30 days. It was reported staff have access to the Psychiatrist by first going through the CC. The Psychiatrist is the Assistant Medical Director for ACT teams for the agency. Staff reported a recent office move of the Psychiatrist has left the team in a different area of the building causing coordination of care of members to be less spontaneous.	• Optimally, the ACT Psychiatrist is available to spontaneously collaborate member care with ACT staff, providing invaluable education related to symptoms, medications and side effects, and health issues that members experience, etc. Ensure access to the ACT Psychiatrist is available to all members of the team.
H8	Nurse on Team	1 – 5 5	The ACT team has two FTE Nurses assigned to the team. One Nurse focuses on delivering services to members in the community such as accompanying members to specialty medical appointments. The	

			other Nurse is office based to be available to complete labs, deliver injections, and other medical procedures. Staff report the Nurses are readily accessible to staff by phone and secure text messaging. According to interviews, ACT Nurses rarely care for non-ACT team members.	
H9	Substance Abuse Specialist on Team	1 – 5 3	There is one Substance Abuse Specialist (SAS) assigned to the team. The SAS has several years of experience on this team. The SAS receives Integrated Dual Disorders Treatment (IDDT) group supervision weekly by agency staff. Documents provided to reviewers showed independently completed training in both IDDT and Co-Occurring Disorders in the last 12 months.	• Fill the vacant second SAS position. Optimally, ACT teams are staffed with two SAS positions, each with a year or more of training and experience providing substance use treatment. Prioritize specific training and experience treating dually diagnosed adults using a co-occurring disorders model when hiring for the SAS position.
H10	Vocational Specialist on Team	1 – 5 3	At the time of the review, the team had two Vocational Specialists (VS) assigned to work with members of the team. The Employment Specialist (ES) has been in the role for seven months and the Rehabilitation Specialist (RS) has many years of experience working with members in behavioral health, but neither are experience in assisting members in finding and retaining competitive employment. Both staff show enthusiasm for supporting members, but only one participated in training related to employment and rehabilitation per records provided.	• Ensure that both vocational staff receive ongoing training in assisting people diagnosed with SMI/co-occurring diagnoses to find and retain competitive employment. Training should include techniques to engage members to consider employment; job development strategies; the importance of supporting in-person employer contact soon after members express an employment goal; and the provision of follow-along supports to employed members. • Support VS staff in attending regional quarterly meetings where they can obtain information on local resources as well as connect with other VS for further collaboration.
H11	Program Size	1 – 5 5	The ACT team has 11 staff and is adequately staffed to serve the 98 members assigned to the	

			team. One position was open at the time of the review, the second SAS position.	
O1	Explicit Admission Criteria	1 – 5 4	Based on ACT staff interviews, the team follows the Regional Behavioral Health Administrator's (RBHA) ACT Admission Criteria. In the past, the AS normally completes the screening, reviews with the CC, and the CC then discusses with the Psychiatrist to make a determination. Staff describe a new process implemented by the RBHA in that staff assignment for screening of referees may be for another ACT team, thereby, some members admitted since the new process has been standardized would indicate members of the team may have been screened by an ACT specialist from another team. Staff reported the team Psychiatrist has the final say.	• Screenings for admission to the Metro Omega team should be conducted by ACT staff of that team.
O2	Intake Rate	1 – 5 5	Per the data provided and an interview with ACT leadership, five members were admitted to the team in the six months prior to the review. This rate of admission is appropriate.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric and medication services, substance use treatment services, and employment/rehabilitative services. The team does have a Licensed Associate Counselor partially allocated, 20%, to provide counseling and psychotherapy to members of the ACT team. It was reported seven members are engaged in those services; however, this staff only attends one treatment team meeting a week. Additionally, some members of the ACT team have been referred to outside brokered providers for specialty treatment relating to trauma.	• ACT services should be fully integrated into a single team. The team should assist members to find housing in the least restrictive environments, which can reduce the possibility for overlapping services with other housing providers. • Support the LAC to attend a minimum of two program meetings a week to support the coordination of member care.

			Per observations, records reviewed, and interviews with staff, the team has several members residing in housing that has non-ACT staff on-site providing duplicative services of ACT teams.	
O4	Responsibility for Crisis Services	1 – 5 5	Staff interviewed reported that the team provides a sheet to members with all staff roles and numbers listed. In addition, the "on-call" number is listed for afterhours contact, as well as a backup on-call number. A copy was provided and listed current staff and their positions. Staff provide this list to members at intake and assist them in programming the numbers into member phones. One member interviewed stated using the team when in crisis in the past. Staff offered support over the phone and another time met with the member in the community.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Based on review of information provided with staff, the team was involved in 70% of the 10 most recent psychiatric hospitalizations. Staff stated that normally members will contact the team and be offered an appointment with the provider. When hospitalization is recommended, the team will call for an open bed, transport the member, and stay with them until admitted if allowed by the hospital. Some hospitals are not allowing staff to wait with members due to the public health emergency. In those cases, staff will provide supporting documentation and hospital staff will contact the team to inform of the result. Of the members that the team was not involved, two sought admissions independently without reaching out to the team. One other member was assessed by the team after expressing suicidal	• Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can aid them during the admission, especially if members have a history of seeking hospitalization without team involvement. • 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 relationships with natural supports.

			ideation, was offered assistance by the team to be admitted, but the member declined. The member was sent in a taxi; however, the team did not follow along to the hospital.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Per review of the ten most recent psychiatric hospital discharges, the team was involved in 90%. Staff report that they always participate in discharge staffings with hospitals. Reviewers were informed the agency policy states that ACT staff cannot transport members but instead send them home by cab. Staff report the team will transport certain members. When the team does assist in transporting members when discharging from an inpatient psychiatric facility, they will obtain discharge paperwork, address medication changes by use of the on-site pharmacy at the clinic, and the Psychiatrist will review those changes with the member. The team provides five days of follow up beginning the day after the member is discharged during which the member will see the Psychiatrist again. The team will then meet with the member once a week for the next four weeks. Staff said this is primarily done by telehealth per agency request. One record reviewed showed a member was hospitalized. The team documented three telemed visits and coordination of care with the inpatient team and other stakeholders, however, several of the notes, in this record and others, were entered much later, up to 30 days, after occurring. Coordination occurred once a week to every other week.	• Increase coordination of care while members are inpatient. Continue to build relationships with inpatient staff and use resources available to advocate for member care. Some teams create business cards with team information that members can carry on their person to reference when interacting with other agencies/providers and expedite coordination of care. • Ensure staff are trained in appropriate documentation standards so services are accurately reflected in the members' medical records.
O7	Time-unlimited Services	1 – 5 5	Two members graduated from the team in the past 12 months. Of the current roster of members enrolled, it was projected another two members	

			will likely graduate off the team. The team utilizes an exit criteria tool to determine when members are ready to move to a lower level of care. One criterion is no hospitalizations or crisis stays.	
S1	Community-based Services	1 – 5 2	As mentioned, the agency implemented a restrictive contact policy because of the public health emergency. ACT staff are limited to contact members outside their home by providing "porch visits." Staff reported in special circumstances entering the home is permitted. It was reported the agency policy loosened up public health emergency protocols towards the end of September. Staff can now do visits twice weekly but are still restricted to *porch visits* rather than inside members' homes. ACT staff are assigned caseloads and are expected to see those members once a week at their home. Staff reported that the majority of in-person contacts with members occur in the community. Results from ten randomly selected member charts show only 23% of contacts are occurring in the community. One member interviewed reported the team is providing very limited in-person services and that options are offered such as videoconference and phone contacts. Other members reported going into the office once a month and being offered phone or in-person contact at least once a week.	• Work to increase delivery of services to members in the community to 80% of the time. Continue efforts to engage with members in a manner that they feel most comfortable as public health protocols change. • Ideally, services are delivered in the community, but as conditions improve during the public health emergency, continue to provide, and support members in utilizing resources available, i.e., telemedicine. Members may require assistance when initially accessing new technology and applications. Failure to accessing successfully could cause frustration resulting in members declining the service. The team's technology proficiency can positively impact members' ability to improve their outcomes and reach their goals.
S2	No Drop-out Policy	1 – 5 5	In the 12 months before the review, two members left the team. Staff interviewed report that one member declined services and was moved to Navigator status and another member was on outreach for eight weeks when the team heard	

			they had moved out of state. That member was also moved to Navigator status.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff report the team follows an eight-week outreach protocol when members are not engaged in services. The team will make four attempts to contact the member each week with two of those being out in the community. Staff will search for members at their last known address, areas they are known to wander, and other familiar areas to the member. Staff will reach out to contacts listed in the medical record including legal guardians, payee services, and probation officers, however, noted that this may not occur with frequency. Of member records reviewed, two members had infrequent follow-up from staff and low intensity of service delivery. One member had no contact for two weeks and documentation was entered weeks later after occurring.	• If members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact, i.e., missed appointment. Discuss and track these efforts during the program meeting. Consider peer review of documentation to ensure outreach efforts are accurately included in member records.
S4	Intensity of Services	1 – 5 3	Per a review of ten randomly selected member records, during a month period prior to the fidelity review, the median amount of time the team spends in-person with members per week is 61.5 minutes. One member received medication observation services and averaged more than three hours of direct service from staff a week, yet two members, one hospitalized, received none for the month period reviewed. One member had a telemed appointment with the Psychiatrist, while four others had telephone contacts documented in records. The median contact by phone or by telemed for all records reviewed was less than one contact a week. The median service duration was less than two minutes.	• ACT teams should provide an average of two hours or more of in-person services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on their individual needs, recovery goals, and symptoms. Continue to consider member safety concerns during the public health emergency, providing education on steps members can take to reduce the risk of infection, including vaccination, wearing of masks, and social distancing.

			The fidelity tool does not accommodate delivery of telehealth services.	
S5	Frequency of Contact	1 – 5 2	The median weekly in-person contact for ten members was 1.8, based on review of records. Over a month timeframe, none of the ten members received an average of four or more contacts per week. Per staff report, the agency has implemented a limit to the number of in-person contacts the team can provide to members of the ACT team because of the public health emergency.	• ACT teams were created to provide intensive individualized services to persons unsuccessful with traditional case management practices. ACT members require frequent contact by the team to assess needs and provide ongoing supportive services. Agency leadership should consider member needs when creating and implementing restrictive policies limiting in-person staff contact with members of ACT teams. • Consider options to interact with members with safety measures in place. For example, some ACT teams visit member residences but interact using a phone. The approach allows staff to maintain a safe distance from members yet allows in-person contact. • Identify and resolve barriers to increasing contacts with members. Optimally, members receive an average of four or more in-person contacts a week.
S6	Work with Support System	1 – 5 2	During the program meeting observed, natural supports were mentioned for at least 25% of the members on the team. Additionally, for three psychiatric hospitalizations, natural supports were identified as reaching out to the team for assistance and support for their loved one. Staff interviewed stated anywhere from 20 – 50% of members have a natural support with which the team has contact. One staff stated all the members have a natural support, however, may not share the contact information with the team.	• Continue efforts to engage members' natural support systems as key contributors to the member's recovery team. Staff should model recovery language and provide tips to family members and other natural supports how they can support member care. • Ensure contacts with members' natural supports are documented in member records. Some electronic health record systems support this by simplifying the

			The team tries to connect with natural supports weekly and will offer support when members are struggling with recovery. Records reviewed for ten members showed the team documented interactions with member natural supports an average of 1.9 per member.	process for staff entering encounters. Consider peer review of member records to support documentation of important interactions.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Per interviews with staff, at least 19 of the 45 members with a Co-occurring Disorder (COD) are being provided formal structured substance use treatment services by the SAS on the team. The SAS engages an additional seven members monthly to participate in substance use treatment services. Services are delivered in-person at the office, by phone (15), or videoconference (4). Sessions range from 15 to 45 minutes one to two times a month. Of the records reviewed, three members were engaged with the SAS for one-to-one sessions. The SAS references *Illness Management and Recovery* and *IDDT Recovery Life Skills* manuals for providing treatment services using a stage wise approach and focusing on the wellness goal of each member.	• Train team staff on strategies to engage members in individualized treatment as appropriate, based on their stage of change. Make available ongoing supervision by the SAS, or other qualified staff, to support the SAS's efforts to provide individual substance use treatment. • Hire a second SAS to increase the availability of substance use treatment services to members of the team. Ideally, all members with a dual diagnosis receive on average 24 minutes or more per week of substance use treatment services.
S8	Co-occurring Disorder Treatment Groups	1 – 5 1	The ACT team is not providing members with a COD any substance use treatment groups at the time of the review due to agency public health emergency protocols of the agency. When groups were stopped at the clinic, the SAS attempted to increase one-to-one contacts with members. Reviewers were informed that other groups may occur in the community, however, COD treatment groups were excluded due to concern for member privacy. The team has not offered groups by phone or videoconference to members with a co-occurring diagnosis. The SAS is anxious to restart	• Provide group treatment to members with a COD. Co-occurring treatment groups work best when based in an evidence-based practice (EBP) treatment model. Consider structuring groups around proven curriculum for optimal impact. • Consider offering groups so that at least one is structured for members in the earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach.

			groups which may happen soon per report, recognizing the benefit to members.	• All ACT staff should engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Optimally, at least 50% of members diagnosed with a COD attend at least one treatment group monthly.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Staff interviewed were supportive of the Integrated Dual Disorders Treatment model, integrating mental health and substance use services for each member's care. The team focused on the member's wellness goal and steps they can take to support reaching that goal. Members' stage of change was identified during the program meeting observed. Staff spoke of the endorsement of harm reduction tactics as members work to reduce use or use in a safer environment, or less lethal drug. Staff will step in to offer members other supports, such as job search assistance, when motivated to reduce use and move toward recovery. However, some staff stated that ideally abstinence is the goal. One staff identified the contradiction of hoping for abstinence yet also supporting members' personal goals which may be to reduce use. One staff expressed the SAS role was to address substance use, while other staff's role was to address issues relating to mental health. Of records reviewed, three members had a COD and language used referring to substance use was respectful and supportive of recovery. However, not all had a treatment plan that reflected how the team would address and support the members in steps toward recovery. An additional member, not identified as having a COD, was engaged in weekly	• Provide all specialists with annual training and mentoring in the evidence-based practices of the *co-occurring model/stage-wise approach* including *harm reduction*. Training should involve how to align treatment interventions to the member's stage of change, as well as *motivational interviewing* which will provide staff with skills to engage members in identifying recovery goals. • Continue to discuss members' stages during the program meeting to bring awareness to the appropriate interventions the team should apply as they all work to engage members in recovery. This may also afford the opportunity for modeling and discussion on the use of supportive recovery language. • Ensure treatment plans are from the member's point of view, and outline steps the team will take to address substance use and support the member in recovery.

			one-to-one sessions with the SAS. Personal wellness, safety, and coping skills were common themes.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Not all members interviewed were aware there are staff with lived psychiatric experiences on the team. Staff report there is as least one staff with lived psychiatric recovery and shares their story in an effort to support others with mental illness.	
Total Score:		**106**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	2
3. Program Meeting	1-5	2
4. Practicing ACT Leader	1-5	5
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
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	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	4
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5

5. Responsibility for Hospital Admissions	1-5	4
6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
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	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.79**	
Highest Possible Score	**5**	