AVONDALEASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 6, 2017

To: Jeremy Reed, ACT Team Clinical Coordinator
Frank Scarpati, CEO

From: T.J. Eggsware, BSW, MA, LAC
Jeni Serrano, BS
AHCCCS Fidelity Reviewers

Method

On December 13-14, 2016, T.J. Eggsware and Jeni Serrano completed a review of the Community Bridges Inc. (CBI) Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

CBI operates three Forensic Assertive Community Treatment teams (F-ACT) in addition to the ACT team located in Avondale, AZ, which began operations on November 1, 2015, and is the focus of this review. At the Avondale location, CBI also offers: medical health services; triage, assessment, brief intervention, and transition support through Access Point; and short-term stabilization services through Transition Point.

The individuals served through the agency are referred to as *clients* or *patients*, but for consistency in fidelity reports, the term "member" will be used in this report.

During the site visit, reviewers participated in the following activities:

- Observation of a daily ACT team meeting on December 13, 2016;
- Individual interviews with Clinical Coordinator (i.e., Team Leader), Rehabilitation Specialist (RS), Housing Specialist (HS), and one of the team's two Substance Abuse Specialists (SAS);
- Group interview with nine members;
- Charts were reviewed for ten members using the agency's electronic health records system; and,
- Review of the agency documents and resources, including: *ACT Eligibility Screening Tool* developed by the Regional Behavioral Health Authority (RBHA), agency website, agency ACT brochure, ACT team group calendar, resumes and training records for the team SASs, and training records for the staff identified in the Vocational Specialist positions (i.e., RS and Employment Specialist).

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item

scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team is adequately staffed to ensure a small member to staff caseload ratio, and is of sufficient size to consistently provide necessary staffing diversity and coverage to the 80 members served at the time of review.
- The team is staffed with two Nurses, which in addition to providing adequate coverage to the team, allows for services to be provided in the community or office. Nursing services include filling medication packs, providing injections to members in the office or the community, coordinating medical services, and other general case management activities.
- The team maintains a low admission rate and experienced no drop-outs over the year prior to review, ensuring consistency and continuity of care for members. Staff reported no instances of members who were closed due to lack of contact.
- The agency website outlines ACT services and the 24-hour-a-day, seven day a week Peer Access to Care line. This use of multimedia, in addition to brochures, provides general information to community members about ACT services and how to access the support.

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

- Ensure Vocational Specialist staff receives ongoing supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings. Training areas of focus include: job development, individualized job searches, and follow-along supports.
- Seek to build rapport and trust with members to identify and engage their support systems; educate them on how the team can provide support, if the need should arise.
- Review and formalize the outreach and engagement process followed by the team. Diversify the outreach efforts for members who are not in contact with the team, in addition to street and shelter outreach in specific areas of town, which was documented in records.
- Increase the intensity and frequency of services to members so average frequency of face-to-face contacts is four or more per week, and average intensity of service is two hours or more per week, per member. Work with members to identify activities in their communities that align with their interests, preferences, and recovery goals. Avoid developing groups facilitated by ACT staff that are not outlined in the SAMHSA evidence based practice (EBP) of ACT.
- Train all staff in stage-wise treatment approaches, interventions, and activities for co-occurring treatment. Increase the frequency and diversify the focus of co-occurring treatment groups to accommodate members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). Rely on staff trained in co-occurring treatment to spearhead those efforts. Engage members with a co-occurring diagnosis to participate in individualized treatment through the SASs on the team, as appropriate to their level of treatment.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team serves 80 members with 11 staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of approximately 7:1.	
H2	Team Approach	1 – 5 (4)	Members interviewed reported they have a primary staff contact, but that the whole ACT team is available to provide support. However, some reported that as the team has grown to serve more members, staff are slower to respond or do not make contact as frequently. Staff interviewed reported having assigned caseloads for certain duties, and some staff seemed more familiar with members for whom they were assigned as a primary contact or those who receive medication observation services. Based on ten records reviewed, 70% of members met with more than one staff over a two-week period.	• Ensure all members are served by the full team, resulting in 90% or more of members having face-to-face contact with more than one ACT staff consistently over two week periods. Some teams utilize a zone rotation in addition to specialists making contact with members to address specific goals.
H3	Program Meeting	1 – 5 (5)	Per report, the program meeting is held four days a week, and all members are discussed at each meeting. The team Nurses attend all meetings, unless urgent member issues arise. The team Psychiatrist attends in person three days a week, and by phone one day per week. During the meeting observed, all members of the team were presented for discussion. Conversation varied depending on their status, and topics included: recent appointments, individual counseling services through the team, inpatient status, medical health and treatment, outreach efforts, occasional references to informal support contacts, coordination with external agencies, and coordination with jail or other legal system representatives.	

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H4	Practicing ACT Leader	1 – 5 (3)	Based on available information, it appears the Clinical Coordinator (CC) provides services to members at the office and outreaches them in the community. The CC estimates his time providing direct services to members at around 20%, but noted that some activities, such travel, and transporting members, is not captured in agency productivity reports. The CC attends meetings and has administrative duties in addition to providing direct services. Based on review of the CC's productivity report over a month period, the supervisor provides direct services to members about 12% of the time. In ten member records reviewed, there was one CC contact with a member (in the community) over a month timeframe, but noted outreach efforts were noted in others.	• The CC should provide direct services 50% of the time. Continue efforts to monitor and track CC actual direct service time to members, with a goal of increasing the opportunities to provide direct member services, to model interventions, and support the team specialists. Where possible, streamline or eliminate CC administrative tasks not explicitly connected with his role as an ACT leader. • Ensure all direct member contacts are documented, in addition to outreach efforts.
H5	Continuity of Staffing	1 – 5 (4)	Based on data provided by the agency, three staff left the team, which is a turnover rate of 25%. One of the three staff who left the team was promoted to the role of CC on another ACT team at the agency.	• Continue efforts to hire and retain qualified staff. Work with administration to thoroughly vet candidates to ensure they are the best fit for the position and the demands of an ACT level of service.
H6	Staff Capacity	1 – 5 (5)	The team operated at approximately 95% of staff capacity over the year timeframe, with seven total vacancies over a 12-month period.	
H7	Psychiatrist on Team	1 – 5 (5)	There is one full-time Psychiatrist assigned directly to the 80 member program. Staff report the Psychiatrist attends team meetings, provides community-based services half of one day per week, and is accessible during the day, the evening, and weekends. The Psychiatrist has no other administrative responsibilities, and does not meet with members who are not on the ACT team. Staff reported the Psychiatrist works with them in a collaborative manner to serve members. This	

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			was observed during the morning meeting where the Psychiatrist engaged staff in discussions by probing for information and their perspective regarding the best way to serve members.	
H8	Nurse on Team	1 – 5 (5)	There are two full-time Nurses assigned to the team. Nursing activities occur in the office and community, including: medication services (e.g., injections, medication observations), coordinating with medical health providers, conducting home visits, and assisting members with other activities (e.g., assisting a member to secure identification and documents to apply for benefits). Staff reported that the Nurses are accessible, attend all of the morning meetings, and have no other administrative tasks. The Nurses rotate on-call coverage, allowing for staff consultation after hours, on the weekend, or if they receive crisis calls from members.	
H9	Substance Abuse Specialist on Team	1 – 5 (4)	The team has two SASs, both of whom are Licensed Associate Counselors (LAC). One has been in the position since November 2015, and the second joined the team in October 2016. Resumes reflect both SAS have a broad base of general counseling experience, but somewhat limited experience in substance abuse treatment outside of that gained in their current positions. Based on tracking information provided, Integrated Dual Disorder Treatment (IDDT) training was provided to some staff, but neither SAS was noted to have participated.	• Provide ongoing clinical supervision to SASs on a stage-wise approach to co-occurring treatment, including: engagement, persuasion, active treatment, and relapse prevention. Provide guidance, and training to align staff activities and interventions to each member's stage of treatment. • If IDDT training is offered through the agency, ensure the SAS staff participate, or if necessary, update internal tracking if the training occurred.
H10	Vocational Specialist on Team	1 – 5 (3)	The ACT team currently has two Vocational Specialists, identified as the RS and Employment Specialist (ES). The RS joined the team in November 2015, and the ES joined the team in November 2016. Staff report attending quarterly	• Ensure Vocational Specialist staff receives ongoing supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings. This may fall under the Supported

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			trainings with Vocational Rehabilitation where topics include discussing referrals to external providers of vocational services. Based on tracking information provided, one of the vocational staff attended Supported Employment training. Neither of the vocational staff participated in DB101 training; however, one reported that RBHA staff introduced them to the website. It is not clear if both vocational staff have at least one year of training and experience in assisting members to obtain employment in integrated settings.	Employment training offered if the focus is on the ACT vocational's staff role in directly providing vocational services. • The RBHA should consider incorporating into the quarterly meetings with VR what aspects do or do not apply to ACT vocational staff. For example, ACT staff should not refer to outside providers for vocational services to assist members to obtain employment, so covering the topic without clarification may cause confusion.
H11	Program Size	1 – 5 (5)	The team is of sufficient size to provide coverage, with 11 direct service staff.	
O1	Explicit Admission Criteria	1 – 5 (5)	Members join the ACT program through referrals from other provider clinics, and through the RBHA. Staff meet with members to discuss ACT services prior to admission. Screenings for ACT are conducted by the CC or other staff, using the *ACT Eligibility Screening Tool*, and that information is reviewed with the Psychiatrist and team. The team and member make the final determination whether the individual will join the team. The CC reports no administrative mandates to accept members who are determined inappropriate by the ACT team.	
O2	Intake Rate	1 – 5 (5)	Per report, recruitment efforts when the team began offering services included: creating a brochure, visiting clinics, visiting hospitals, introducing the team to staff in the service area, and educating them on how to make referrals to the team. Admissions to the team over the six months prior to review ranged from three to six members per month, and the peak rate occurred in August 2016. Members interviewed confirmed that ACT services are voluntary.	

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O3	Full Responsibility for Treatment Services	1 – 5 (4)	In addition to case management, the team directly provides psychiatric services and substance abuse treatment services, which includes a combination of group and individual counseling. Some members receive counseling/psychotherapy through the team, with one member who receives the service from an external provider per their preference, but the service was in place before the member joined the team. The team appears capable of providing a wider array of counseling; for example, one of the SASs has experience providing Dialectical Behavior Therapy (DBT), and another has experience in family counseling based on review of their resumes. It is not clear if the team fully provides employment/rehabilitative or housing services. Though it appears some members are supported through the team to explore vocational goals, some reportedly were introduced to Disability Benefits 101 (DB101), and assisted to search for employment in the community. However, some members are referred to external agencies for employment services. The team provides in-home services, and assists members to explore housing options if the need arises, but it appears more than 10% of members are in staff settings where other social service staff may provide support. These settings include community living residences, recovery homes/ half-way houses, and the CBI facility Transition Point, where about half the members interviewed confirmed they had stayed over their course of treatment on the team.	• Ensure staff receives monitoring, support, and supervision specific to their role. Training focus areas for vocational staff include: job development in the community, aligning the job search with member goals, disclosure, and follow-along supports. See recommendations for H10, Vocational Specialist on Team. • Work with members to locate safe, affordable, and integrated housing in the community where ACT staff are the primary service provider with a goal of reducing the number of members who receive in-home support from brokered providers (i.e., providers who are not part of the ACT team).
O4	Responsibility for Crisis Services	1 – 5 (5)	ACT staff reported that the team is available through the team's on-call phone, with coverage that rotates every four days among direct service	

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			staff. The number is forwarded to each staff's company smartphone so there is no need to exchange a separate phone. One of the team Nurses is on-call for staff to contact after hours or as needed, in addition to the Psychiatrist who is available to staff for consultation. Documentation reflected services that occurred at various hours of the day and night and were completed by specialists and Nurses. Members interviewed confirmed that staff are available 24 hours a day, seven days a week.	
O5	Responsibility for Hospital Admissions	1 – 5 (4)	Staff report the team is involved with nearly all admissions. Based on review with staff, the team was involved in nine of the ten most recent admissions. One member was petitioned for court-ordered evaluation (COE) by staff at another CBI program, and the ACT team was involved after the event that prompted the COE request. Overall, it appears the team works to build rapport with members to seek alternatives to admissions, and if needed, will assist voluntary members with admissions. The team also completes applications for COE or amendments to court-ordered treatment (COT) if involuntary members are determined to be in need of further evaluation or treatment in an inpatient setting.	• Optimally, the ACT team is involved in all decisions to hospitalize ACT members. Work with each member and their support network to discuss how the team can support members in the community to avert, or to assist in a hospital admission, if the need should arise. Develop plans with members in advance, especially if they have a history of admitting without informing the team, of leaving the state without informing the team, etc.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	Staff estimated the team is involved in nearly all hospital discharges. The team was involved in the ten most recent member psychiatric hospital discharges based on review with the CC. During member hospitalizations ACT staff maintains contact with the inpatient Social Workers (SW), and the team Psychiatrist conducts doctor-to-doctor consultations to discuss medications and treatment. After discharge, the team schedules five days of face-to-face contact with the member.	

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O7	Time-unlimited Services	1 – 5 (5)	Per staff report, few members left the team over the 12 months prior to review, and no members graduated due to significant improvement. It was projected that three members (4%) were likely to graduate in the next twelve months.	
S1	Community-based Services	1 – 5 (3)	Staff reported they are rarely in the office (e.g., only for morning meeting), spending about 80% or more of their time in the community. The rate of community-based services documented in ten member records reviewed showed that a median of 56% of services occurred in the community. That rate included three members who had no community-based contacts for the month timeframe reviewed, but four of the ten members received 80% or more contacts in the community. Some members interviewed reported they prefer to go to the office frequently to attend groups facilitated by ACT staff, and as a result those members indicated they frequently meet with staff in the office, while others who elect not to attend groups reported they meet with staff in the community. Some reported that staff visits with them at their home weekly, but all members may not receive weekly home visits. It is not clear if groups facilitated by ACT staff limit their ability to provide a higher level of individualized community-based services to members.	• The ACT team should increase community-based services to members, with the goal of 80% of contacts being made in the community versus the office setting. Prioritize individualized contacts with members in their communities, where staff can support them to connect with their natural supports, or identify resources. Co-occurring treatment groups are part of the SAMHSA ACT EBP, but other groups facilitated by the ACT staff are not specifically called out in the model and should not be used in lieu of individual encounters to achieve member contacts. • See also recommendation for S3, Assertive Engagement Mechanisms.
S2	No Drop-out Policy	1 – 5 (5)	Based on data provided for the year prior to review, no members closed due to the following: the team determining they could not be served, refusing services, could not be located, or due to moving out of the geographic area without referral. One member left the geographic area with referral, but shortly after moved back to the service area and rejoined the team.	

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S3	Assertive Engagement Mechanisms	1 – 5 (3)	Per report, the ACT team uses outreach and engagement mechanisms, including: searching the streets and shelters, contacting hospitals to determine if members are inpatient, coordinating with Probation Officers or other legal system representatives, contacting informal supports if known, and attempting to meet members at last known addresses. However, it is not clear if a formal written process is followed. Of the ten member records reviewed, three were not in contact with the team. No outreach was noted in one record over a month timeframe. Street and shelter outreach was noted in two of the three records over a month timeframe reviewed, sometimes twice in a day in the same area, but it was not clear if other outreach was also occurring. In one of those records, documentation indicated that the team was informed the member was incarcerated, but there was no visit or attempted visit documented for 12 days; when the team did visit, they were informed the member was released the day prior.	• Formalize and document the outreach and engagement process followed by the team. Diversify the outreach efforts, to include a combination of street and shelter outreach, in addition to other efforts. Ensure all efforts are documented so that staff is aware of outreach that has occurred, and aligns subsequent outreach with the member's individualized outreach plan. If a member is out of contact with the team, and the team confirms their location, attempt to meet with the member to engage them as soon as possible in an effort to build rapport and trust.
S4	Intensity of Services	1 – 5 (2)	The median intensity of service per member was about 42 minutes a week based on review of ten member records. One member received over 209 minutes of average service time per week over a month period, and another received about 162 minutes of average service time per week over the same period. However, four members received an average of just 40-46 minutes of service time per week over the same timeframe.	• Increase the intensity of services to members, optimally averaging two hours a week or more of face-to-face contact for each member. Work with staff to identify and resolve barriers in increasing the average intensity of services to members. Ensure all services are documented. • See also recommendation for S3, Assertive Engagement Mechanisms.
S5	Frequency of Contact	1 – 5 (2)	Ten member records were reviewed to determine the amount of times per week each member is receiving face-to-face contact. The median face-to-face contact was two per week over a month	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member, with an

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			timeframe. The average contacts per member per week ranged from zero to about six. Members who attend groups or receive medication observation services reported a higher frequency of contacts with multiple staff.	emphasis on community-based services to support specific member goals. Work with staff to identify and resolve barriers to increasing the frequency of contact with members. Ensure all services are documented. • See also recommendation for S3, Assertive Engagement Mechanisms.
S6	Work with Support System	1 – 5 (2)	One staff reported that about 36% of all ACT members have informal supports, with the team averaging just under four contacts a month with those supports. A second staff estimated that about 50-60% of all ACT members have informal supports, with the team averaging about weekly contact with those supports. Another staff reported five of seven members assigned to them have informal supports, and the team averages weekly or more contact with those supports. Contact with informal supports or plans to outreach informal supports were infrequently discussed in the team meeting observed, for about 15% of members, though in one instance the Psychiatrist had phone contact with a member's family to formulate a plan for the member to live with the support. In ten member records reviewed, the team averaged .5 contacts per month with informal supports, with a range of zero to three contacts. Seven member records showed no contacts with informal supports during the month.	• Ensure ACT staff review with members the potential benefits of engaging with informal supports, and include supports in treatment, when people face challenges, to celebrate success toward recovery, and to educate informal supports about ways to support member recovery. • On a recurring basis, revisit with members to identify their informal supports. For example, review with members engaged in member run programs whether they have established informal supports with others who also attend. The ACT team has some members involved with member run programs, so there may be opportunities to identify and build on informal supports they develop by interacting with other individuals at those locations.
S7	Individualized Substance Abuse Treatment	1 – 5 (4)	Staff reported that all staff provide substance abuse counseling. However, it appears only the SASs provide formal and structured counseling, supported by documentation in one of the ten member records reviewed. The senior of the two	• Train SASs and make available ongoing supervision to support their efforts to provide individual substance use treatment. The recent addition of a second SAS should allow the SASs more time to

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			SASs reported that 11 of the 61 members are scheduled with her weekly for individual sessions, which may be shorter than an hour in duration if they are late to appointments (e.g., if there are transportation issues). Contacts by ACT staff other than the SASs included meeting with members in the community, engaging family in the treatment process, asking members if they are willing to discuss substance use, seeking to build awareness that things could be different for the member, etc. Records reflected that members experiencing substance use challenges were inconsistently engaged to discuss the substance use concerns, so it does not appear that these encounters qualify as individualized substance abuse treatment.	provide individualized substance use treatment in addition to group treatment. If other specialists are expected to provide individualized treatment, they should also receive training and guidance to provide co-occurring treatment. • The agency should explore mechanisms to monitor and track individual substance use treatment activities without creating additional paperwork for direct care staff. Engagement efforts should be tied to a proven, co-occurring treatment approach, with staff activities documented that align to each member's stage of treatment. See also recommendations for S9, Co-occurring Disorders (Dual Disorders) Model.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (3)	Per report, the SASs on the team facilitate one co-occurring treatment group weekly which draws from an integrated dual diagnosis treatment model, and RBHA materials that seems to focus primarily on members in the persuasion stage of treatment. Per report, of the 61 members who have co-occurring diagnoses, 18 attended at least one recovery group in the month prior to review, based on review of sign-in sheets. The SASs also offer an art group, but based on review of the reference material used to develop the course, it appears to draw more from a 12-step model of recovery than a co-occurring approach, so members who participated in that group were not included in the calculation in this item.	• Increase the frequency, and/or number, of co-occurring treatment groups offered through the team. Increase outreach efforts to encourage more member participation in co-occurring treatment. • See recommendations for S9, Co-occurring Disorders (Dual Disorders) Model. Review whether the art group can be aligned with a co-occurring approach to treatment. Co-occurring treatment should include engagement groups, to meet the needs of members who are ambivalent about treatment, so there may be an opportunity to adapt the art group in that regard.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (3)	The SAS interviewed is familiar with a stage-wise approach, as well as stages of change. During the morning meeting staff occasionally noted what efforts were made to address substance use, using	• Train staff in a stage-wise approach to treatment, interventions that align with a member's stage of treatment, and how to

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			a harm reduction approach, and during interviews examples of harm reduction were provided. One staff was familiar with pharmacological interventions utilized by the team, but another staff was unsure how widely it was used on the team. Based on interviews, some staff are familiar with the stages of change, but less familiar with a stage-wise approach. Some of the team approach draws from a 12-step model of recovery rather than a co-occurring approach (e.g., art group curriculum). Based on training tracking, not all staff have been trained in the identified co-occurring model (i.e., IDDT). Only one staff received training in IDDT, but most have at least some training in motivational interviewing. Detoxification may be used, if medically indicated based on substance used; some members are involved in Alcoholics Anonymous (AA), but it is not the primary method of intervention utilized by the team. Documentation in ten member records did not consistently reflect a co-occurring treatment approach when staff had contact with members with known substance use issues.	reflect that treatment language when documenting the service. This may better equip other ACT staff to engage members in individual and group SA treatment through the team. • When appropriate, based on a member's stage of treatment, offer individualized treatment in addition to co-occurring disorder treatment groups. For members in earlier stages of recovery, work with members to build awareness of the problem; seek to assist members to envision a future without substance use, etc. • During clinical supervision, review with staff how to support members who elect to participate in AA.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	The ACT team has a full-time PSS, in addition to other staff on the team who are individuals with a lived experience of recovery from substance use, mental health conditions, etc. Some members interviewed reported staff share their personal stories of recovery, including times when staff faced similar experiences, struggles, or challenges.	
Total Score:		**4.04**		

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	4
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	5
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	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	3
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	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.04**	
Highest Possible Score	**5**	