ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 21, 2016

To: Kelly Harshberger, Quality Management Director, Integrated Health Services

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AHCCCS Fidelity Reviewers

Method

On October 25 – 26, 2016, Karen Voyer-Caravona and Jeni Serrano completed a review of the Chicanos Por La Causa (CPLC) Centro Esperanza 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.

Chicanos Por La Causa is a community development corporation that provides housing, early childhood education, work force and economic development, and health and human services to urban and rural communities in Arizona, New Mexico, and Nevada. Behavioral health services, including substance abuse treatment, are offered to children, families, individuals, and older adults. Beginning in November 2015, CPLC assumed ownership of People of Color Network (PCN) clinics, including the Centro Esperanza clinic.

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

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

- Observation of a daily ACT team meeting;
- Individual interview with team leader/Clinical Coordinator (CC);
- Individual interviews with a Substance Abuse Specialist (SAS), Housing Specialist (HS), and Rehabilitation Specialist (RS);
- Group interview with three members receiving ACT services;
- Charts were reviewed for ten clients/consumers using the agency's electronic medical records system; and
- Review of agency documents: ACT Outpatient Team Morning Meeting Notes, Clinical Coordinator' Encounter Report, Outreach Tracking form, Regional Behavioral Health Authority (RBHA) developed ACT Eligibility Screening Tool and ACT Exit Criteria Screening Tool, November 2016 ACT Team Group Calendar; and
- Review of resumes for the Employment Specialist and the Rehabilitation Specialist, and one handwritten summary of an SAS's employment and credentialing history.

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 ACT team benefits from two Substance Abuse Specialists with training and experience to provide the necessary range of substance abuse treatment services and cross-train staff representing other areas of specialization.
- The ACT team uses the specific ACT admission criteria developed by the RBHA and does not report administrative pressure to accept inappropriate referrals to the team. Additionally, the CC shares responsibilities for screening admissions with the rest of the team specialists.
- The ACT team provides members with time unlimited services with fewer than 3% of members expected to graduate in the next 12 months.
- The ACT team retained 97% of its membership over the last 12 months.

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

- The Clinical Coordinator should spend 50% of her time providing direct member services, especially community-based services.
- The ACT team should increase both the intensity and frequency of weekly community-based contacts. While intensity and frequency of face-to-face community-based contacts can be expected to vary depending on member needs, they should average at least two hours and at least four contacts with multiple staff each week.
- The ACT team should increase engagement members' to an average of four or more contacts per week for each member's informal supports should be cultivated whenever possible as partners in aiding member recovery.
- With two qualified Substance Abuse Specialists positions, the ACT team should become fully responsible for substance abuse treatment services to ACT members diagnosed with a co-occurring disorder (COD), including:
    - Engaging at least 50% of members diagnosed with a COD in at least one group per month.
    - Providing formal, individualized substance abuse treatment averaging at least 24 minutes per week for members diagnosed with a COD.
- The agency and the RBHA should provide on-going training and education, including support of cross-training by the Substance Abuse Specialists, in a stage-wise approach to co-occurring treatment and corresponding best practice interventions.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The Centro Esperanza ACT team consists of 95 members receiving services from 11 staff: a Clinical Coordinator (CC), an ACT Psychiatrist, a Nurse, two Substance Abuse Specialists (SAS), a Housing Specialist (HS), an Employment Specialist (ES), a Rehabilitation Specialist (RS), an ACT Specialist (AS), and a Peer Support Specialist (PSS). Excluding the Psychiatrist, the staff to member ratio is just under 1:10.	
H2	Team Approach	1 – 5 5	Per a review of ten randomly selected electronic member records, members saw multiple staff 90% for the most recent two week period under review. Staff gave varying accounts of how many members they see in a typical day, with estimates of five on the low end and 16 on the high end. Staff attributed lower numbers to some staff still being new to the team. Staff said that people who come into the clinic on a daily or near daily basis may receive more contacts. When making home visits or other community-based contacts, staff said they also try and see other members who live in the surrounding area. One staff member is trying to orient newer staff to this contact strategy and that the team has a "sheet that shows where everyone lives."	
H3	Program Meeting	1 – 5 5	The ACT team meets together five days a week from 9:30 a.m. – 11:30 a.m. The meeting observed by the reviewers was led by the CC with the active participation of most staff in attendance, including the ACT Psychiatrist. All staff attended the meeting except for one who was directly attending to member needs outside the clinic. Staff were provided morning meeting notes on the entire roster of members. All	

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			members were discussed, many in a fair amount of detail regarding concerns such as housing needs; income, rent, and budgeting concerns; and relationships with family.	
H4	Practicing ACT Leader	1 – 5 3	While the CC estimated that she spends approximately 20% of her time providing direct member services, her encounter log of actual time showed the CC rate of member direct contacts to be at 10%. The CC's low rate of contact may be attributed to a focus on attaining full staffing. The CC said that she likes to go out into the community with the Psychiatrist and the Nurse but that, due to being short staffed she, mainly sees members in the clinic. She expects to be able to increase her community based contacts now that the team is fully staffed.	• At least 50% of the ACT CC's time should be spent providing face-to-face member services. • Review CC's administration tasks to determine if any can be transitioned to other staff at the clinic, such as the Program Assistant, to allow the CC more time to provide direct member service, model meaningful interventions, provide community-based mentoring and shadow the team specialists.
H5	Continuity of Staffing	1 – 5 3	In the last 24 month, 12 staff left positions for a turnover rate of 50%. Several members interviewed noted the repeated loss of staff and expressed hope that current staff will stay on the team.	• Maintain staffing level so that turnover does not exceed 20% in two years to support therapeutic rapport, staff cohesion, and maximize benefits of training in the ACT model and the co-occurring disorders treatment approach. • Seek feedback from staff to identify factors that contribute to staff turnover and retention via surveys, suggestion box, and exit interviews.
H6	Staff Capacity	1 – 5 3	The sum total of staff vacancies for the last 12 months was 33, for a capacity rate of 77%. Based on analysis of the data provided and staff interviews, the positions of Nurse, SAS, and ES appeared to be the most difficult to fill.	• See Recommendation for H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a team Psychiatrist who is fully dedicated to serving the ACT team, working four, ten hour days each week. Staff interviewed said that the Psychiatrist does not have any	

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			responsibilities outside the ACT team, attends Tuesday through Friday program morning meetings, is approachable and accessible by phone and email, and conducts home visits every Thursday. Staff said that the Psychiatrist only sees other agency members in rare emergencies when the other Psychiatrists are not available. Members interviewed spoke positively of the Psychiatrist as well.	
H8	Nurse on Team	1 – 5 3	The ACT team has one Nurse, who joined the team in early September 2016. Members and staff interviewed praised the Nurse as caring, personable, and accessible to staff and members. The Nurse conducts Wednesday home visits to ensure that members who miss Psychiatric appointments or injections are seen. Staff said the Nurse helps with prescriptions, triages members before they see the Psychiatrist, meets with members to perform annual assessments, and attends medical appointments with members to advocate for their healthcare needs. The Nurse works five days a week, attends all morning team meetings, and does not have responsibilities outside the team. The CC reported that although the team has sought to have two filled Nurse positions for over a year, the team has only had one Nurse during that time.	• Fill the second Nurse position to provide coverage for both the clinic and community-based services.
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has two Substance Abuse Specialists, each with significant experience in co-occurring disorders treatment. SAS1 has been with the team since early 2015. Prior to joining the team he reported that he worked for two years as a Clinical Coordinator at an SMI clinic where he facilitated substance abuse groups,	

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			under the supervision of a Licensed Independent Substance Abuse Counselor (LISAC). His experience also includes 3.5 years working at a drug and alcohol treatment center and as a Case Manager at another SMI clinic. The SAS1 is pursuing a Masters in Professional Counseling and has had three graduate level courses in substance abuse treatment. In addition, he has received about 60 hours of substance abuse treatment through the online training platform of the RBHA. The SAS2 is a LISAC and joined the team a week prior to the fidelity review. Before employment at Centro Esperanza, the SAS2 provided individual and group counseling at a residential treatment program, and came highly recommended by the SAS1, a previous co-worker. Per a written summary of his professional background, the SAS2 was worked in substance abuse for nearly 25 years in a variety of settings, including a boarding school, as a bilingual DUI counselor, various co-occurring clinics, and a co-occurring Native American residential treatment program.	
H10	Vocational Specialist on Team	1 – 5 3	The ACT team employs both an Employment Specialist and a Rehabilitation Specialist. At the time of the review, the RS had been in the position since May 2015. Per interviews, the RS and the ES help members with resumes and interviewing skills, provides them job leads, connects them with peer support training, and transports them to job fairs. The CC reported that the RS has eight years of experience supporting teenagers and young adults find employment and acquire life skills. Additionally, she has been a certified tutor for over ten years. The CC said the RS has had training through the RHBA and the Vocational	• Provide immediate training, education, and mentoring for the ES in the provision of vocational services.

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			Rehabilitation Administration (VR). The RS has a Masters degree in Social Work and a Bachelors Degree in Psychology. The ES joined the team in early September. According to her resume that was provided to the reviewers, the ES's previous experience is in case management at two SMI clinics for slightly under two years. She also worked as a Rehabilitation and Respite Worker for 2.5 years providing in-home occupational therapy to children and adults with special needs. Although, the ES has a Bachelors degree in psychology her resume did not reflect vocational training or experience. The CC reported that the ES had received vocational training from the RBHA and VR but could not provide details. The ES's lack of relevant training and experience in vocational services is reflected in the score.	
H11	Program Size	1 – 5 5	Staff and members interviewed reflected challenges to coverage and care due to staff shortages throughout the past year. However, in September and October the team has filled six vacancies. At time of review the team is at 11 staff with only one vacancy of the second RN position. The team is currently of sufficient size to provide staffing diversity and coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The CC provided the reviewers with the explicit admission criteria developed by the RBHA, which the team uses to guide admission screenings. Referrals to the team originate primarily from psychiatric hospitals, supportive teams throughout the system, and other teams in the clinic. The CC or another staff member conducts the screenings. The CC reports no administrative pressures to accept referrals that do not meet the ACT	

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			admission screening criteria. The CC said that a few members probably do not need the intensity of the ACT team at this time and have expressed interest in stepping down to a lower level of care.	
O2	Intake Rate	1 – 5 5	In the last six months, the ACT team has admitted seven members: two in May, three in June, and two in August. The CC said that the team never admits more than six in one month.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management services, the ACT team directly provides psychiatric services and most housing services. No members were identified as receiving psychiatric services outside the team. Nine members live in some type of staffed setting; three members are being transitioned to a supportive team, and the rest receive most services from the ACT team. Substance abuse groups were suspended due to the recent staffing shortage for three months prior to the review, so the team was not able to provide sufficient data to calculate average monthly attendance. Additionally, the SAS2, a LISAC, has just joined the team and has not yet begun providing individualized substance abuse treatment. The SAS1 provides psychoeducation in substance abuse and engagement only, typically during scheduled home visits. Currently, two - three members receive substance abuse treatment from outside providers. Credit could not be given for the team providing vocational services at this time. The ES recently joined the team and is still engaging with members and learning the scope of the position. The RS uses a RBHA developed Vocational Activities Profile to assist members in identifying strengths,	• With the team almost fully staffed, ensure that members are cross-trained in all the specialty areas to respond to member needs as they occur. • Now that the ACT team has two qualified SASs to provide substance abuse treatment, the team should implement strategies to engage members with a COD in group and individual treatment. • Since the ACT model does not require that staff providing services be licensed, consider providing clinical oversight to the unlicensed SAS1 to allow him to provide individualized co-occurring treatment. • Provide on-going training and mentoring for the ES and RS on approaches to assisting members in finding and retaining employment in integrated settings. • In addition to the licensed SAS2 providing individual counseling/psychotherapy, provide clinical oversight to other staff with the educational background to provide counseling psychotherapy, such as the CC, the RS, and the SAS1 in order to avoid referring this service outside the team.

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			creating resumes, and connecting with peer support training or jobs. The RS has been working closely with VR and a co-located provider for those members who the team feels need sheltered employment rather than competitive employment. It was not clear that the RS was familiar the ACT team's role in assisting members to obtain employment in *integrated* settings versus settings such as sheltered workshops and work adjustment training. Two members receive traditional employment services through an outside provider, and one receives job coaching through a VR program. Credit could not yet be given for counseling/psychotherapy services. Members have been receiving this service outside of the team, sometimes in therapeutic relationships established prior to the member joining the ACT team. Approximately four members receive outside counseling/psychotherapy. The SAS2 has been charged with providing these services going forward.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team is fully responsible for providing members with crisis services. The CC said that there is an on-call phone. The CC is the back up and all members have the number to the on-call. ACT staff are available 24 hours a day, seven days a week. All calls are forwarded to staff work cell phones in place of the blue dot crisis call system and members interviewed stated they are aware they can call the staff cell phone numbers after clinic hours any time or day of the week. The CC is available 24/7 as a back up and if an on-site response is deemed necessary then the CC determines who responds. Some members	

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			reported that they did not have an updated contact list reflecting new staff.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The ACT team was directly involved in nine out of the last ten (90%) psychiatric hospitalizations. In most cases, the member was seen by the team Psychiatrist at the clinic, and staff transported the member to the hospital. Staff remain with the member through admission and begin coordination of care with hospital social workers and other staff. In two cases, members were amended by staff and taken to the hospital by the police. One member who was hospitalized for a medical issue was transferred to a psychiatric hospital without the knowledge of the team when he began displaying psychiatric symptoms. The team was informed after the transfer. With a similar hospital transfer, the team was contacted immediately by the hospital for coordination of care. Another member ingested cleaning fluid at his residential placement. The team was alerted immediately by the facility staff after emergency services was called; the team coordinated care from thereon.	• Continue to efforts to coordinate care with PCPs and other medical providers to ensure the ACT team is immediately notified when members hospitalized for physical health concerns begin showing psychiatric symptoms.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The ACT team was responsible for 100% of the last 10 psychiatric hospital discharges. The ACT team begins working with hospital social workers immediately after admission, setting up doctor-to-doctor discussions, attending staffings, and coordinating with family or other supports when appropriate. Staff visit members who are inpatient at least every 72 hours. When members are discharged, staff picks them up from the hospital, ensures prescriptions are filled, assists the member with picking up any necessary groceries or personal care items from the store, and takes the member to wherever they are living.	

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			The member is seen by the ACT Psychiatrist within 72 hours of discharge, usually at the clinic. Staff see the member every day for the first five days after discharge to support safe transition back into the community. Staff said that they mostly have no problems working with psychiatric hospitals on discharge coordination, although one facility sometimes discharges members to the street.	
O7	Time-unlimited Services	1 – 5 5	The ACT team offers members time unlimited services. No members graduated from the team in the last 12 months. The CC said that participation on the ACT team is voluntary, and that the three members anticipated to graduate from the program in the next 12 months all asked to be stepped down. The ACT team uses an ACT Exit Criteria Checklist. Members who ask to leave the team meet with the team Psychiatrist who gives his opinion. Staff clarifies for the member what to expect from a lower level of care. The team decreases home visits little by little to see how members function with decreased contact. Usually transfers occur to a supportive team within the clinic or agency unless the member requests another provider. ACT staff attend the transfer staffing to the receiving team, and members are assured that they can return to the team at any time.	
S1	Community-based Services	1 – 5 4	Per the review of ten randomly selected member records, the ACT team provides community-based services 75% of the time. Most community-based contacts for home visits to assess living environments and monitor for immediate needs. Two records showed evidence of staff responding to crisis or potential crisis situations at the home. Some staff may rely on clinic-based contacts to	• Increase delivery of community-based member services to 80%. • Rather than encourage members to come to the clinic, staff should focus on providing community-based services where staff can more effectively assess, monitor, and assist in problem solving and skill building. Avoid implementation of site-based groups not

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			help them attain encounter expectations; the reviewers were provided a copy of the November 2016 ACT Team Group Calendar with several groups (Arts and Crafts, Grief and Loss, Men's Group) offered at the clinic in addition to co-occurring groups.	specifically referred to in the evidenced-based ACT protocol.
S2	No Drop-out Policy	1 – 5 5	The ACT team retained 97% of its membership for the last 12 months. Two members refused services. Both members were being actively served by the team. Although the team was working with one member on obtaining social security benefits, the member stopped communicating with the team, which the CC attributed to frustration with the housing process. Another member stopped communicating with the team due to being focused on working with the Department of Child Safety on family reunification requirements. Both members were outreached by the team but refused services. Both cases have been closed, but the individuals can restart services at any time.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team uses a four-week outreach and engagement outreach tracking sheet to record efforts when members have not been in contact with the team. Each week listed prompts staff to perform specific outreach tasks such as: Week 1 – phone contact, home visit, ER contact; Week 2 – mail intent to close, call primary care provider, call jail hotline, etc. The CC described the staff using street outreach such as going to members preferred locations; searching shelters; contacting known associates; and contacting payees, guardians, and informal supports. The CC said staff efforts at engagement account for the low drop out rate on the team. The ACT team discussed specific outreach efforts, including	

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			contacts with informal supports and street outreach activities, in the morning meeting observed by the reviewers. Although the team has four week protocol, outreach often exceeds the timeframe, depending on the member's history, with closure as a last resort. Staff said members' cases can easily be reopened if they come back.	
S4	Intensity of Services	1 – 5 2	Per the record review, ACT members receive an average of 45.38 minutes of services per week from staff. Averages per record reviewed ranged from a low of 15 minutes per week to a high of 85 minutes per week.	• The ACT team should provide members an average of two hours of face-to-face contact weekly. Intensity may vary based on where the member is in recovery, but an average of two hours across the team should be the goal. Contacts should be person-centered, based on needs, recovery oriented, and delivered in the community to best promote skill building and new knowledge (see recommendation for item S1, Community-based Services).
S5	Frequency of Contact	1 – 5 2	Per the record review, ACT members were seen by staff an average of one time weekly, with a range of between .75 visits per week to 2.25 visits per week.	• The ACT team should provide members with an average of 4 contacts per week (see recommendations for items S1, Community-based Services, and S4, Intensity of Services). • Review barriers to achieving recommended contacts with staff and brainstorm ideas to enhance this important part of the ACT service. • The CC should periodically monitor staff contacts and review as part of professional development.
S6	Work with Support System	1 – 5 2	Staff estimated that 75% - 80% of members have an informal support system. The CC said that they have at least one contact per month with an informal support for about 50% of members with a support network. The reviewers found that 50% of	• Document team contacts with member support system(s) in a consistent fashion, to ensure this measure is being accurately captured. • Continue to educate members on the

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			records reviewed had at least one contact. The average contact for all records reviewed was .60 contacts per month.	benefits of and encourage the involvement of informal supports. Obtain and update release of information forms (ROI) as needed to allow contact. • Outreach members' informal supports on a regular basis to maximize their role as ACT team partners who may benefit from support and psychoeducation as well as provide valuable feedback on needs, strengths, and successes.
S7	Individualized Substance Abuse Treatment	1 – 5 1	At the time of the review, the CC and the SAS1 reported that 55 of the 95 members were diagnosed with a co-occurring disorder (COD). No COD diagnosed members were receiving individualized substance abuse treatment at the time of the review. While the team addresses substance abuse concerns with members, it is currently rebuilding its substance abuse program after being short-staffed and only having one SAS. For three out of the last 12 months, the SAS1 worked on the team only 25 – 30 hours per week. The SAS1 provides individual psychoeducation on substance abuse with members diagnosed with a COD during scheduled home visits, but he stated he does not provide individual substance abuse treatment because he is not licensed and cannot bill for the service. The SAS2 is licensed but had only been with the team one week at the time of the review and was in the process of accepting referrals and building rapport with members identified with a COD. The reviewers did not find evidence of individualized substance abuse treatment in the reviewed member records.	• The team should ramp up efforts to outreach and engage members with a co-occurring disorder in individualized substance abuse treatment. Consider using examples of other peers who have benefitted from treatment. • Do not limit substance abuse treatment to the LISAC on the team. The fidelity protocol only requires that counseling be performed by a staff with at least one year of training and experience in substance abuse treatment. • Provide all specialists with ongoing training and mentoring in the principles of the co-occurring model/stage-wise treatment approach.
S8	Co-occurring Disorder Treatment	1 – 5	For the three months previous to the review, the weekly substance abuse group had been	• Staff should recruit members to attend co-occurring treatment groups so that at least

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	Groups	1	suspended due to insufficient staffing to provide coverage. Staff interviewed said the team just started offering the substance abuse group the Friday before the review and that five members attended. The SAS1 said that the group will align with the Integrated Dual Diagnosis Treatment (IDDT) model but does not have a curriculum for the group at this time. Insufficient data due to lack of substance abuse groups is reflected in the score for this item.	50% of members diagnosed with a COD attend at least one group per month. Ongoing training in the dual diagnosis model for all staff specialists, including cross training by the SASs, may increase member engagement in co-occurring groups (see recommendations for item S9, Co-occurring Disorders Model). • Ensure that any curriculum used to facilitate group aligns with the co-occurring model. Offer multiple co-occurring treatment groups to serve members in various stages of treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The ACT team appears to approach substance abuse treatment from a mixed model approach. Staff interviewed know that the system is moving toward the use of IDDT model, and the CC said the team had received training in it. Staff interviews, however, indicate that the team is still learning about the co-occurring model, being familiar with *stages of change, harm reduction and motivational interviewing* but not necessarily applying them as components of the *stage-wise treatment approach*. Though acknowledging reduction in use as a step toward recovery, some staff interviewed view abstinence as the treatment goal. Likewise, some staff said the ACT team does not have the resources to help members who are actively using and in dysfunctional relationships, and that those need residential rather than community-based treatment.	• The agency and RBHA should provide ongoing education and training to all ACT staff on a dual disorders model, such as Integrated Treatment for Co-Occurring Disorder, the stage-wise treatment approach, and motivational interviewing, and accommodate for new or less experienced staff. Standardizing a basic tenant of treatment may help ensure consistent interventions across the system.
S10	Role of Consumers on Treatment Team	1 – 5 4	The ACT team has a Peer Support Specialist whose role is equal to that of other specialists. The PSS was originally hired to the team as the Employment Specialist but changed to her present	• The PSS should be recognized by members and staff as a person with lived experience with and of serious mental illness and/or a co-occurring disorder. The PSS provides a

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			position in September 2016. It was not clear from staff and member interviews the extent to which the PSS has disclosed her relationship with lived experience of and with psychiatric disorders.	model of recovery, for both members and their informal supports, inspiring hope that change is possible. The PSS helps ensure a member perspective in service design and delivery.
Total Score:		**3.79**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	5
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	3
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	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
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	1
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	4
Total Score	**3.79**	
Highest Possible Score	**5**	