ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 27, 2019

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AHCCCS Fidelity Reviewers

Method

On November 4-5, 2019, T.J. Eggsware and Karen Voyer-Caravona completed a review of the Southwest Network San Tan Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Southwest Network staff provides services to children, adolescents, and adults. Adult services are delivered at four outpatient clinics. Per the agency website, services are available to support members to identify and accomplish goals in the areas of: employment and education pursuits; independent living; and; building and maintaining connections with friends, family, and members' communities. The agency operates three ACT teams in the Central Region of Arizona. This review focuses on the San Tan ACT team.

The individuals served through the agency are referred to as *members* or *behavioral health recipients*, 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:

- Observation of a team meeting on November 5, 2019;
- Individual interviews with the ACT Clinical Coordinator (i.e., Team Leader), a Substance Abuse Specialist (SAS), Peer Support Specialist (PSS) and, the Employment Specialist (ES);
- Group interview with six members who receive ACT services from the team;
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of documents, including: Clinical Coordinator (CC) face-to-face service tracking report, staff resumes, substance use group sign-in sheets, substance use treatment resources, the Southwest Network *Lack of Engagement Desktop Procedure* and *Lack of Contact Checklist*, formal support contact lists, and, the Regional Behavioral Health Authority (RBHA) *ACT Admission Screening Tool*, and *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual*.

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 meets four days a week to discuss members. During the team meeting observed, multiple staff contributed to discussions. Contributions by staff included tasks related to specialty roles, such as supporting independent living, the provision of substance use treatment, and employment goal engagement or delivery of employment support.
- The team is staffed with 12 staff, sufficient to provide the necessary coverage to the 96 members served. The member-to-staff ratio is about 9:1. The team operated at approximately 96% of staff capacity over the prior year.
- The team is staffed with a Psychiatrist and two Nurses. Interviewees reported that the Psychiatrist and Nurses provide community-based services and are accessible. There were multiple examples of the Psychiatrist providing community-based services documented in the sample records reviewed. The San Tan ACT team Psychiatrist appears well positioned to advise other ACT Psychiatrists that provide fewer community-based services on how to balance the provision of office and community-based services.
- The ACT team provides crisis support to members. Staff from the team is available after business hours by phone and can meet members in the community. Members interviewed said that staff rotates on-call coverage weekly.
- The team maintained consistency and continuity of care for members, with a low admission rate for the period reviewed. The team retained the majority of members, or, transitioned their service to another provider or system of care.

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

- Evaluate what prevented staff in directly supporting members during hospital admissions. Maintain regular contact with members and their support networks, which might result in the identification of issues or concerns that could lead to hospitalization.
- Evaluate how the team can engage or enhance support to members who receive a lower frequency and/or intensity of service. Monitor documented outreach and contacts with members and evaluate the team's approach to building rapport with disengaged members.
- Increase engagement with natural supports as partners in supporting members' recovery goals. Training staff on strategies for engaging informal support may be helpful. Staff may then be able to give informal supports tips on how they can reinforce healthy recovery behaviors or utilize recovery language when they interact with members.
- Provide training to staff on stage-wise treatment, associated interventions, and strategies to engage members in individual and/or group treatment. Both SASs should receive supervision so they can cross-train other specialists in substance use treatment. Evaluate the content of the substance use treatment groups to ensure the use of a co-occurring treatment approach.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 96 members with 11 staff that provide direct services, excluding the Psychiatrist, resulting in a member to staff ratio of 9:1.	
H2	Team Approach	1 – 5 5	One staff said staff contacts with members are tracked on a spreadsheet and member calendars. Staff said that all members receive face-to-face contact with more than one staff over a two-week time frame. Based on sample records, 90% of members received face-to-face contact with more than one staff over a two-week period.	
H3	Program Meeting	1 – 5 5	Staff said that all members are discussed during the team meeting, held weekly Monday - Thursday. The meeting is longer on Thursdays to allow for discussion of paperwork. Specialists attend on the weekdays they are scheduled to work. The Psychiatrist attends full meetings two to three times weekly. All members were presented for discussion, which varied in detail. Staff reported on their recent or planned contact for nearly all members. Staff discussed their coordination with medical care providers.	
H4	Practicing ACT Leader	1 – 5 3	The CC reported providing direct services 40-50% of the time. In ten records there were few examples of CC services over a recent month, none were direct services to members, but the CC was on leave for 64 hours during the time frame. Based on review of the CC's productivity report over a recent month time frame, the CC provided direct services about 27% of the time. An additional recent month with only one holiday was provided that showed the CC provided direct services about 21% of the time.	• Optimally, CC's delivery of actual time spent in direct services to members should account for at least 50% of the time and be documented in the members' records.
H5	Continuity of	1 – 5	The members experienced staff turnover in the	• Ideally, turnover should be no greater than

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	Staffing	4	prior two years. Based on data provided, six staff left the team since November 2017, a turnover rate of 25%.	20% over a two-year period.
H6	Staff Capacity	1 – 5 5	The team operated at approximately 96% of staff capacity over the prior year. There was a total of 6 months with position vacancies. The ES was the only position vacant for multiple months.	
H7	Psychiatrist on Team	1 – 5 5	During the team meeting observed, the Psychiatrist actively participated, discussed contacts with members and recent contacts with the informal supports, for some members. Staff said that the Psychiatrist is accessible, including after hours. If the need arises, on-call staff contacts the CC who then contacts the Psychiatrist or directs the on-call staff to call. Most members reported that they meet with the Psychiatrist every three weeks. One member said that the Psychiatrist visited them at their home. In sample records reviewed there were multiple examples of the Psychiatrist providing community-based services. In addition to traditional duties (e.g., providing medication information and prescribing), interviewees reported that the Psychiatrist provides additional supports, such as guiding members to enhance their independent living skills and discussing housing options.	
H8	Nurse on Team	1 – 5 5	Two full-time Nurses are assigned to the team. Staff reported that each Nurse attends team meetings two to three times per week. Staff reported that the Nurses are accessible and responsive, including over the weekend and after hours. Staff said that the Nurse who has been with the team longer takes a lead working with people with challenging medical issues, but generally, the Nurses split coverage on the team. Examples of	

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			the Nurses providing services to members in the community were found in records. Staff said that the Nurses do not provide services to members served by other teams at the clinic and neither have other duties outside of the team.	
H9	Substance Abuse Specialist on Team	1 – 5 4	The team is staffed with two SASs. One of those staff transitioned from ACT Specialist to SAS in October 2018. The first SAS's resume shows attendance in a Master of Social Work program. Staff reported no participation in substance use curriculum through that program to date. The SAS's training record shows participation in eight applicable sessions. Based on review of their resume, the second SAS worked for six years in the same position at another clinic before transitioning to the role of Rehabilitation Specialist. This SAS joined the San Tan team in May 2018. The staff's training records beginning in 2009 show participation in ten relevant substance use treatment sessions. Both SASs participated in trainings for American Society of Addiction Medicine (ASAM), two sessions for one SAS and three sessions for the other SAS. The SASs participated in co-occurring disorders and motivational interviewing trainings. The limited training provided to staff is reflected in the score. Also, no supervision of the SASs specific to their specialty position was reported.	• Provide both SASs with supervision and training in co-occurring treatment best practices. SASs may then be better equipped to cross-train other staff on the team in the adopted co-occurring model and appropriate interventions based on members' stages of treatment.
H10	Vocational Specialist on Team	1 – 5 5	The team employs an ES who joined the team March 2019. The staff previously worked on ACT teams. The ESs training records since 2007 show some applicable training. The Rehabilitation Specialist (RS) joined the team in September 2008.	• The ES may be a resource to vocational staff on other teams who struggle to engage members in considering competitive employment. The ES may be able to share the strategies used to engage

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			Based on the staff's training records and resume, the RS attained more than a year experience in employment support services. Based on staff interviews and observation of the team meeting, the ES engages members to explore employment options or opportunities to increase their skills. There were examples in records reviewed of the vocational staff discussing socialization and employment options with members. The ES met with one member and attempted to redirect them from a sheltered workshop, discussed the benefits of competitive employment, and assisted with the job search.	members and balancing the specialist ES role with other ACT duties.
H11	Program Size	1 – 5 5	At the time of review, with 12 staff, the team is of adequate size.	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported that referrals stream through the RBHA to the team or are directly referred from other providers. The team uses the *ACT Admission Screening Tool* developed by the RBHA to screen potential admissions. The CC or other staff meets with potential members to complete the screening. At the screening, staff provide an overview of ACT, such as the frequency of contact, and explain that ACT is voluntary. If a member meets criteria and accepts ACT services, the screening information is reviewed with the Psychiatrist who determines if members join the team. Staff reported no administrative pressure to admit members to ACT.	
O2	Intake Rate	1 – 5 5	Over the prior six months, the peak member admission rate was three during June 2019. There were two admissions October 2019; one admission August 2019; and, zero admissions May, July, and	

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			September 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides case management, psychiatric services, substance use treatment, and most housing and employment support service. During the team meeting, staff discussed assisting members with independent living skills such as grocery shopping and budgeting. Based on staff interviews and observation of the team meeting, the vocational staff engages members to explore employment options or opportunities to increase skills. Staff said the team provides employment related support to 10-25 members, but one member receives service through a brokered provider. Staff said that members transition off the ACT team after 30 days in residential treatment. Based on staff interviews, 8-10% of ACT members are in staffed locations, ranging from formal settings to less formal group living arrangements. In addition, three members are in staffed settings due to medical challenges and three members are in a staffed care home setting where they have lived for more than ten years. Counseling or psychotherapy is not available through ACT staff. Staff reported that they can assist members to develop coping skills but no counselor works on the team. Staff said that members may be referred to a brokered provider for specialty counseling.	• Counseling/psychotherapy should be available on ACT teams. • Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff support. • Monitor the number of members in staffed residences so that, optimally, no more than 10% reside in settings with other social service staff.
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the ACT team is available to provide crisis services 24 hours a day, seven days a week, including responding to members in the	

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			community. The CC is involved in after-hour crisis calls and is available to coordinate with the Psychiatrist and/or Nurse. Staff provided, for review, a form that is given to members with a description of ACT. The form identifies how to contact ACT staff during clinic hours and the team on-call number. The form contains position descriptions about how specific staff can help members. The form identifies phone numbers for the Psychiatrist, the CC, the Program Assistant, and specialists. Members interviewed confirmed that staff is available after hours.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff said that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide their services when members are inpatient. Staff said that they meet with members within 24 hours of being informed of an admission, including over the weekend. Subsequent hospital visits with members occur weekly on Monday, Wednesday and Friday. Staff reported that the Psychiatrist attempts doctor-to-doctor consults with inpatient providers. Based on information provided, the ACT team was directly involved in most of the ten most recent hospital admissions. One member experienced an overdose and following medical clearance, the team coordinated with the inpatient staff to transition the member to a facility for psychiatric treatment. The team was not involved in two admissions: one member was petitioned by the police and a second member was brought to the hospital by a family member. Staff reported that they did not offer to meet the family and member at the hospital.	• Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions. • Maintain regular contact with all members and their support networks. This may result in identification of issues or concerns that could lead to hospitalization, allowing the team to offer additional supports, which may reduce the need for hospitalization.

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O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said that the ACT team was directly involved in each of the ten most recent hospital discharges. Staff from the team usually meets members at discharge to provide transportation. Staff said that when members are discharged they have follow-up appointments with the Psychiatrist within 72 hours. If members are unhoused or staff suspect they may not return for an appointment, staff attempt to arrange for an appointment with the Psychiatrist the day of discharge. Staff said that typically, members meet with a Nurse within five days of discharge. Staff said that they have face-to-face contact with members for five consecutive days after a hospital discharge.	
O7	Time-unlimited Services	1 – 5 5	Staff reported that over the prior year, three members graduated from the team. Staff projects three to five graduates in the upcoming year. Staff said that the graduation rate is tracked on a report provided to the RBHA. Staff reported that the process is driven by members achieving certain milestones, such as: no recent psychiatric hospitalizations, no crisis calls, or employment.	
S1	Community-based Services	1 – 5 4	Some members reported staff usually meet them in the community, including at staff-facilitated community-based activities (e.g., visiting a local shopping center). One member reported visiting with staff more often at the member's home; two members reported they usually meet with staff at the office; and, two members reported a mix of community and office-based contacts. One staff reported delivering 65-75% of direct member services in the community, while another staff reported spending about 80% in the community. In ten member records, a median of 76% of services occurred in the community, an increase from the	• Continue efforts to increase the delivery of services to members in their communities.

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			team's prior review.	
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the prior year, the team retained the majority of members, or, transitioned their service to another provider or system of care. Staff said that no members closed from ACT due to refusing services, not being located, or the team determining they could not be served. A *Navigator* system is in place, but no members transitioned off the team to that status in the prior 12 months, per staff report. Staff reported they assisted all members who moved from the geographic area to connect with new providers. Staff reported three members transitioned off the team due to placement in 24-hour residential treatment; one member who transitioned off ACT upon entering another system of care; and, two members who transitioned to a lower case management service level following their admissions to the Arizona State Hospital.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff said that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide their outreach when members are not in contact with the team. Staff also follows the Southwest Network *Lack of Engagement Desktop Procedure* which indicates that outreach for ACT members should occur for eight weeks, and should include four outreach attempts per week, two of which are conducted in the community. The Southwest Network *Lack of Contact Checklist* lists eight weeks of outreach, and an additional four weeks for high-risk members. Staff interviewed reported different outreach timelines: one said that the team conducts outreach for six weeks, another reported outreach occurs for eight weeks, and one said the	• Monitor documented outreach and contacts with members. It may be useful to assign one staff to spot-check documentation in member records during the team meeting to confirm recent contacts or outreach efforts are documented. This may enable the team to proactively assign staff to outreach or contact in the event of lapses. • Review with staff the outreach procedure, checklist, and expected time frame for outreach to occur. • Seek to balance coordination with formal supports and legal system representatives with a non-coercive, supportive approach to member services. Consider discussing

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			team performs outreach for 12 weeks. In records, over a month time frame, there were gaps in documented outreach or contact of a week or more for four of ten members. One member was incarcerated but released on a Saturday and staff did not document outreach until the following Friday. Staff documented three outreach attempts over a two-week period for another member. One member self-admitted to a facility to receive assistance with placement. ACT staff informed the member's Probation Officer and an arrest warrant was processed. ACT staff coordinated with justice system representatives for the member's arrest at discharge from the treating facility.	under what circumstances it is appropriate to coordinate with legal system representatives to arrange for the incarceration of members.
S4	Intensity of Services	1 – 5 2	The median weekly intensity of face-to-face service time spent per member was 43 minutes based on ten member records. The average weekly service per member ranged from zero to 224 minutes. Service time delivered to two members was higher than the sum of services provided to the other eight members.	• The ACT team should provide members an average of two hours of face-to-face contact weekly. Evaluate how the team can engage or enhance support to members who receive a lower intensity of service.
S5	Frequency of Contact	1 – 5 3	Members interviewed reported meeting with two to five staff over the prior seven-day period. There was a median of two weekly face-to-face contacts for ten members, based on records. Documented contacts with members in ten records range from zero to 15, but five members received fewer than two contacts weekly. Two of the ten members received more than four weekly contacts. Staff contacts with two members exceeded the other eight members combined.	• Increase the frequency of contact with members, preferably averaging four or more face-to-face contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. Seek to balance services delivered to more frequently visited members (e.g., 15 visits weekly) with members who staff meet with less often.
S6	Work with Support	1 – 5	Staff estimates of members with informal (i.e.,	• The team may benefit from further training

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	System	2	natural) supports ranged between 36-75%. Staff said that the team attempts to make contact with informal supports weekly. Staff said that contacts with informal supports are occasionally tracked on member calendars during the team meeting. During the program meeting observed, staff discussed recent or planned contact with informal supports, for less than ten members. Based on records, the ACT team has infrequent contact with informal supports. In ten records, over the course of a month, staff documented a total of eight contacts with informal supports, five contacts with supports of one member, and one contact each for three members. Some members said that staff has occasional contact with their natural supports. One member said that staff might contact their supports if the member was not complying with treatment or experienced an increase in symptoms.	on the benefits of informal supports and strategies to assist members in building and engaging natural supports. Discuss with members the benefits of involving their supports in their treatment. • Educate informal supports about how they can support members' recovery. For example, assist them to identify community-based activities they can engage in with members. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or model use of recovery language.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported that the team serves 56 members with co-occurring diagnoses. Individual treatment was discussed during the team meeting, with the SASs reporting on completed and planned contacts. Staff interviewed reported that all 56 members should receive individual sessions but one interviewee was uncertain how many members received treatment in a recent month time period. One interviewee said at least 50 members receive weekly sessions, each contact lasting 30 minutes or more. Examples of individual treatment contacts were found in records, but no members received individual treatment at the frequency or duration reported by staff. The records were similarly representative of the members with a co-occurring diagnosis on the	• Work to increase the time spent in individual sessions so that the average time is 24 minutes or more across the group of members with co-occurring diagnoses. • Monitor member engagement and participation in individual substance use treatment. • Consider training staff on strategies to engage members in substance use treatment. • Evaluate if SAS participation in other duties, such as medication observation, limits their ability to engage or provide individual substance use treatment. Consider shifting those duties to other staff if indicated.

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			team. Data showed five of the ten members in the sample have a substance use diagnosis.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	Staff said that two co-occurring groups are available, open to members in varied stages of change. One staff reported about 9-13% of members with a substance use diagnosis attended group treatment over a recent month period and another staff said more than 50% attended. Based on sign-in sheets, over a recent month time frame, 20-23% of members with a substance use diagnosis attended group treatment at least once. Over a month time frame, documentation in sample records showed one applicable member participated in group treatment.	• Engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring group. • Consider adapting one group for members in earlier stages and one group for members in later stages. It should allow staff to adjust their interventions to better serve members in different stages of treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Staff said that the team does not refer to Alcoholics Anonymous (AA) or similar groups. Staff said that the team occasionally refers members for medical withdrawal management and gave examples of substances likely to require that support. Staff gave examples of harm reduction, techniques to reduce the number of cigarettes smoked during a day, and using less of a substance. Staff said that they use cognitive behavioral techniques and motivational interviewing. Staff said that the team is trained and uses Integrated Dual Disorder Treatment (IDDT), but staff was not familiar with the term *stage-wise* treatment. Training records did not show that staff participated in IDDT. Staff is familiar with stages of change and reported the stage of change for some members during the meeting observed. To guide treatment, staff said	• Review with staff how IDDT and stages of change are distinguished. There are resources online that can introduce staff to the complimentary aspects of the two models: IDDT; and, stages of change. • Train all staff in a stage-wise approach to treatment, including how specific interventions are directed to members depending on their stage of treatment. Training staff in a comprehensive stage-wise treatment model may help the team to maintain consistent service if SASs transition off the team. Optimally, consistent evidence-based co-occurring treatment is provided. • Staff may benefit from training on strategies to engage members in individual and group substance use treatment. • Consider reviewing with staff techniques to introduce recovery language into conversation with members and support

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			that the team uses *Group Treatment for Substance Abuse A Stages-of-Change Therapy Manual*. Staff said they were uncertain if all staff were trained to use the stages of change treatment manual. One interviewee was uncertain if both SASs regularly use the manual for their treatment groups. Some member treatment plans reviewed address substance use, such as information about group and individual substance use treatment in the services section. However, two applicable members' plans included sobriety-focused content. It was unclear if the information mirrored the members' goals or staff's prerogative. One plan listed that a member was "pre-contemplative for cessation of substance use" and that the member "remained homeless of their own volition." One plan did not address substance use. It does not appear all staff use recovery language. The name of a group is *Clean and Serene*.	systems. Consider monitoring documentation for recovery language. • Ensure member expressed goals are documented on service plans, minimize jargon, and avoid blaming-language.
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff and members interviewed said that there is a staff on the team who has personal lived experience of psychiatric recovery who shares aspects of their story, when applicable.	
Total Score:		**4.25**		

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	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	5
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
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	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
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	**4.25**	
Highest Possible Score	**5**	