ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 11, 2021

To: Kristina Robert, Clinical Coordinator
Dr. Shar Najafi-Piper, Chief Executive Officer

From: Annette Robertson, LMSW
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AHCCCS Fidelity Reviewers

Method

On November 30 – December 1, 2020, Annette Robertson and Karen Voyer-Caravona completed a review of the Copa Health West Valley 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.

The West Valley ACT team was managed by Partners in Recovery. Since the last fidelity review, Partners in Recovery merged with Marc Community Resources, Inc. and is now known as Copa Health. Copa Health operates several outpatient centers. Copa Health offers employment related services, day program activities, integrated health, and residential services.

Due to the COVID-19 public health emergency, it was determined that the record portion of the review should be documentation for a period prior to the public health emergency. Reference in this report to the member records reviewed and related documentation are for the period prior to the public health emergency. Due to the public health emergency, the review was conducted remotely, using video or phone contact to interview staff and members.

The individuals served through the agency are referred to as members or clients, 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 an ACT team meeting via teleconference on November 30, 2020.
- Individual interviews with the Clinical Coordinator (i.e., Team Lead), Independent Living Specialist, and Rehabilitation Specialist.
- Group interview with the two Substance Abuse Specialists (SAS).
- Individual phone interviews with three members that receive ACT services from this team.

- Copies of documents were reviewed for ten members for a 30-day period prior to the public health emergency.
- Review of documents: Regional Behavioral Health Authority (RBHA) *ACT Admission Criteria*; resumes and training records, the Clinical Coordinator encounter report, and substance use treatment resources.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries, and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Although the Psychiatrist is providing temporary coverage, they are readily accessible to the team, flexible, attend program meetings, and schedule appointments with members every 30 days via Zoom. The team employs two Nurses that are accessible to the team, including after hours.
- The team has two SASs on the team with training in Motivational Interviewing and Integrated Dual Disorder Treatment.
- The team follows explicit admission criteria and has a low rate of intake and graduations from the team.
- Members are supported by the team when discharged from psychiatric hospitals.
- There is a low drop out rate of members on this team.

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

- Increase contacts with members in the community, tying in their natural supports to build a network for members. This may impact the high rate of members self-admitting to psychiatric hospitals without the support of the ACT team if supports have regular contact with the team.
- The intensity and frequency of the delivery of services to members of the team should increase using a diversity of staff, including the CC, with understanding that member's needs change and that the team should be responsive to those needs. Without frequent and thorough contact from the team, issues can be missed and exacerbate over time.
- The team is not providing substance use treatment groups that members can access.
- Fill the vacant Peer Support Specialist position. Ensure adequate training and supervision are provided to alleviate staff concerns of stress and potential burnout.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, the team had ten full time equivalent (FTE) staff, not including the psychiatrist or administrative staff, delivering services to a roster of 99 members.	
H2	Team Approach	1 – 5 4	Staff interviewed reported that nearly 95% of the members on the team receive direct service from one or more ACT staff in a two-week period. Upon review of ten randomly selected member records for a month period prior to the health emergency, members received direct service from more than one ACT staff in a two-week period 70% of the time. Some client records showed very little variation in contact with staff. Staff conduct weekly home visits with members assigned to their caseload as well as ensuring attendance at Psychiatrist appointments, coordinating with their primary care physician in the community, and informing them of services that are available from the team.	• Increase contact of diverse staff with members. Team staff are jointly responsible for making sure each client receives the services needed to support recovery from mental illness. Diversity of staff interaction with members allows the members access to unique perspectives and expertise of staff, and perhaps more importantly for this team, it prevents burden of responsibility of care on staff.
H3	Program Meeting	1 – 5 5	Staff interviews indicate the ACT team meets four days a week, excluding Fridays, and the Psychiatrist attends all scheduled team meetings by phone. The Nurses attend on days they are scheduled to work. During the meeting observed by reviewers, the Psychiatrist was present, and staff discussed all members on the roster, some at more length than others.	
H4	Practicing ACT Leader	1 – 5 3	The CC estimated spending 60% of their time in direct service with members of the ACT team. The CC reports to assist with medication observations, crisis calls, home visits, and outreach efforts.	• The CC should provide face-to-face services to members 50% or more of the time. Increase direct services to members. Shadowing and mentoring specialists

			Documentation sent to reviewers regarding actual in-person time spent with members for a month period just prior to the fidelity review showed 20% of their time being in direct service; and most contacts appeared to be brief, unscheduled, clinic-based check-ins, prompts and reminders. *The tool only measures direct in-person contact.*	delivering community-based services are included as direct service delivery. • Evaluate processes and responsibilities that could be reassigned to the program assistant or other staff on the team to allow the CC more face-to-face contact and intervention with members.
H5	Continuity of Staffing	1 – 5 3	Based on information provided, the team experienced turnover of 58% during the past two years. At least 14 staff left the team during this period. Two members interviewed expressed concern with the high turnover of staff on the team.	• Examine employees' motives for resignation and attempt to identify causes for turnover and opportunities for improving staff retention. ACT teams should strive for a turnover rate of less than 20%. Maintaining consistent staffing supports team cohesion, reducing the potential for staff burden. • Ensure candidates being considered to fill vacant positions are prepared to deliver ACT level services, particularly for those candidates without prior experience working in the ACT model.
H6	Staff Capacity	1 - 5 4	Of the information provided, some data appeared missing or inaccurate and could not be clearly accounted for in the interview with staff. A request for clarification was made, however, data was still unclear or missing. It appears the team had 88% staffing capacity for the twelve months prior to the review.	• Fill vacant positions as soon as possible to ensure diverse coverage and continuity of care for members.
H7	Psychiatrist on Team	1 – 5 5	The team has a full-time psychiatrist assigned to the team. Although the psychiatrist is a temporary staffed position, staff report the Psychiatrist attends the program meeting via phone on days they are scheduled. Staff report the psychiatrist is easily accessible by secure text, phone, or email. The Psychiatrist sees clients by Zoom or phone. Members can come into the clinic to utilize Zoom	• Hire a permanent psychiatrist to be assigned to the team full time to provide services to members.

			there if they do not have that resource on their own. For members unable to come to the clinic, staff will assist by facilitating Zoom meetings at their home. Staff report some members prefer to conduct their monthly appointments by phone and one member interviewed reported to prefer in-person meetings. Staff report they support members that do not feel safe coming into the clinic and try to accommodate their needs.	
H8	Nurse on Team	1 – 5 5	The ACT team has two FTE Nurses. Both work four ten-hour days and a Nurse is available to clients five days a week. Staff interviewed reported they are both accessible to the team in person, by email, text, and phone. Nurses are on call after hours. Staff report the Nurses spend one day in the community a week; however, only one of the ten member records reviewed had those services documented. Staff further report Nurses reconcile member medications delivered by the pharmacy, deliver injections, order labs and refills for medications, coordinate medication delivery to clients by staff, train staff on proper protocols for medication observation, among other duties. A Nurse was present at the program meeting observed by reviewers. Occasionally, the Nurses provide services to members on other teams.	
H9	Substance Abuse Specialist on Team	1 – 5 4	Two SASs are assigned to the team to deliver substance use treatment services to members. The first SAS has been in the role since 2016 and is a Licensed Associate Substance Abuse Counselor, receiving weekly individual supervision with the agency from a former LISAC. Relias training documents showed this SAS completed at least 10 hours of training in treating co-occurring disorders (COD) in the past 12 months. The second SAS	

			started in the position in August of 2020 and does not have any prior experience delivering substance abuse treatment services to individuals with a serious mental illness (SMI), although they were enrolled in a Master of Addiction Counseling program in the past. Training records indicate this SAS completed at least 10 hours in Motivational Interviewing and five hours of COD training. Additionally, it was reported that all SASs with this agency receive weekly group supervision.	
H10	Vocational Specialist on Team	1 – 5 3	The team has two Vocational (VS) on the team. The Employment Specialist (ES) has more than one-year experience supporting individuals find and keep employment in integrated settings. Records sent to reviewers show 12 hours of Motivational Interviewing and nearly five hours of training related to employment supports in the past 12 months for the ES. Member records reviewed showed the ES supporting two different employed members. One member was experiencing an increase in symptoms due to the stress of returning to work and was supported by the ES. The second Vocational Specialist, a newly appointed Rehabilitation Specialist (RS), has no previous experience delivering clinical services to individuals with an SMI, nor was there any relevant training in supporting individuals to obtain and maintain work in an integrated setting.	• Provide training to the RS on how to support members to seek, obtain, and maintain employment in an integrated work setting. Ongoing supervision should be provided to support skill development during this first year in the role.
H11	Program Size	1 – 5 5	The team is adequately staffed with 11 full-time employees, not including the Program Assistant, and of sufficient size to provide ACT services.	
O1	Explicit Admission Criteria	1 – 5 5	Based on interviews with staff, the team follows the ACT admission criteria developed by the RBHA. Typically, the CC screens each new referral and the accompanying documents, but staff report	• The ACT team and system stakeholders may want to consider offering clarifying training/education to inpatient psychiatric hospitals. Use times when coordinating

			everyone on the team is trained to complete a screening. After screening, the CC brings the information to the Psychiatrist and the team to discuss the member's needs and if the member meets eligibility. The Psychiatrist makes the final decision about whether a referral is appropriate. If determined eligible for ACT, the team will offer ACT services up to three times before closing out the referral. Staff report in the past year there were several referrals of members that were new to the RBHA system. If a referral is determined ineligible for ACT services, the team must complete a report explaining the decision. Staff report this is a burden as they often receive inappropriate referrals from inpatient psychiatric hospitals.	care with inpatient staff to further their understanding of what eligibility factors are necessary for a member to be appropriate for referral.
O2	Intake Rate	1 – 5 5	The intake rate has been appropriate. The ACT team reports six admissions in the six months prior to the review. Staff reported the team's highest intake month was June 2020 with three admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The ACT team is responsible for case management, psychiatric services, most housing support services as some members are in semi-staffed and staffed housing, substance use treatment, and employment and rehabilitative services. Documentation in member records showed evidence of monthly scheduled appointments with the Psychiatrist, and delivery of substance use treatment services in both individual and group settings. The team does have access to ACT housing, but the team delivers all services to those members. In one record, the team supported a member living independently whose water had been shut off for several days and even though the	• Be careful not to minimize the importance of regular assessment of member mental and physical needs, even when having frequent contact with the team. • Consider options to include staff on the team that can provide individual counseling to members. • Ensure outside providers are aware that in the model of ACT, members should receive all services from the team, i.e., employment services, and that referral to outside agencies/programs works against the Evidence Based Practice (EBP) of ACT.

			team was completing daily medication observations, it went unnoticed. During the team meeting, and documented in records, there were examples of staff supporting members with employment goals or encouraging members to identify socialization or employment goals. Staff report more then ten members are employed part or full time and several more are interested in work. The team is not responsible for providing counseling/psychotherapy to members of the team. Staff report more than ten members receive counseling services off the team. This service is provided by Copa Health staff, but the staff person is not listed on the ACT roster as a (partial) team member.	
O4	Responsibility for Crisis Services	1 – 5 5	Based on staff interviews, the team provides 24-hour crisis support, rotating on-call responsibilities weekly among most staff on the team. The ACT CC is the alternate and back-up. Members and some hospitals will call the CC directly if unable to make immediate contact with the on-call staff. The team will go into the community to meet with members after hours and weekends, regardless of the public health emergency, taking necessary precautions. The team sees themselves as the first responders when members are in crisis.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff interviewed report that the team follows a protocol when a member is being assessed for inpatient psychiatric care. The team will assess the member's needs, offer a triage appointment with the Nurse or with the Psychiatrist, and if assessed as appropriate for inpatient treatment, the team will transport to the hospital and sit with the	• Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can aid them during the admission, especially when members have a history of

			member until they are admitted. Staff report few hospitals allow the team to stay with the member until admission. The team will assist the inpatient team with anything they need such as medication logs, last Psychiatric progress note, as well as how to contact the ACT team because staff are not allowed to visit members while inpatient. Based on review with staff, of the ten most recent psychiatric hospitalizations, the team was involved in 50% of admissions. In all five situations where the team was not aware, the members self-admitted without contacting the team.	seeking hospitalization without team support. • Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build rapport with natural/informal supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff interviewed report that the team was directly involved in the ten most recent hospital discharges. Due to the public health emergency, staff are not allowed into hospitals. Coordination of care is conducted Mondays, Wednesdays, and Fridays by phone and staffings are scheduled weekly. Since the ACT team is reliant on the inpatient staff to coordinate contact with members while inpatient, contact is inconsistent. Members may be off the unit when the team calls, but some inpatient staff will make it a priority. When members are ready to be discharged, staff ensure members are aware of the safety precautions necessary and meet at a predetermined area at the hospital to pick up members. Members are scheduled with the Nurse the same day to reconcile medications and the Psychiatrist within 48 hours or sooner. The team provides five days of in-person follow up. Although the team was involved in 100% of the ten most recent discharges, more than one staff reported hospitals discharging members without coordinating with the ACT team.	• Continue efforts to educate and inform inpatient psychiatric hospital staff of the availability of the ACT team to assist in the discharge process for members.

O7	Time-unlimited Services	1 – 5 5	Per staff report, the team expects to graduate three clients to a lower level of care in the next 12 months. Staff report to documenting in members' service plans when they are negotiating terms of leaving the team and stepping down.	
S1	Community-based Services	1 – 5 3	Based on review of ten randomly selected member records, 45% of services were delivered in the community. *The month review period was prior to the public health emergency*. Two client records received all services from the team in the community, while two others had 10% or less in the community.	• ACT teams should deliver 80% or more of their contacts in the community where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting. • For members who are coming into the clinic multiple times a week, the team should explore how to deliver those services in the natural settings where members live. • Ensure all staff engage members in the community at a similar level as what was reported by staff interviewed.
S2	No Drop-out Policy	1 – 5 5	The ACT team retained 97% of membership in the 12-month period before the review. Two members left the service area without referrals; although the team was able to locate their general area for each of them, they were unable to establish contact to complete referrals. Five other members left the team but were either transitioned to other teams or providers or placed on navigation status. Two members that the team was unable to locate, following a period of outreach, were placed on navigator status. One member left the service area without notice; the team located the member and facilitated connection with a behavioral health provider in that location. Two members moved to higher level of care and were transitioned to a	

			supportive team in order to prevent duplication of services.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The ACT team employs an eight-week outreach strategy that includes home visits, phone calls, outreach to natural supports, contact with jails, hospitals, the morgue, going to locations the members is known to frequent, and inquiring with other agencies with whom the member may have contact. Staff said that even without a Release of Information (ROI) the team can inquire as to if a natural support has had contact. The team also uses legal mechanisms such as petitions and amendments to Court Ordered Treatment (COT), and this was found in member records. The record review also showed contact with a member while in jail and providing support at mental health court and a Probation Officer to engage the member with the ACT team. The record review showed one member only having contact with non-ACT staff in groups or individual counseling for 14 days. Two other records showed no evidence of contact or outreach effort with members on COT for eight and 11 days respectively. One of those members had been recently discharged from an inpatient psychiatric facility and remained unstable.	• If members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Discuss and track these efforts during the program meeting. Consider peer review of documentation to ensure efforts are accurately included in member records.
S4	Intensity of Services	1 – 5 3	Per ten member records reviewed, over a month period before the public health emergency, the median intensity of face-to-face service time per member was approximately 58 minutes weekly, with a range averaging slightly over 12 minutes per week on the low end to about 148 minutes per week on the high end. A member record reviewed included multiple groups attended that were facilitated by non-ACT staff. Other services	• The team should continue efforts to provide high intensity services in as safe a manner as possible. When conditions allow, members should receive an average of at least two hours of face-to-face contact with staff weekly. The intensity of services may vary member to member or over time, with some members receiving significantly more and some significantly less depending on immediate and emerging needs.

			delivered by non-ACT staff were noted in other member records as well.	• Providing individualized services can be difficult to accomplish on a team with a high number of groups. Fine tuning new behaviors, coping with symptoms, and managing social interactions in unique, real-life situations where challenges typically occur may be best achieved when provided on an individual level in the community.
S5	Frequency of Contact	1 – 5 3	Records reviewed, over a month period before the public health emergency, showed on average, members had approximately 2.4 visits per week with ACT staff. The range showed an average low of .5 contact to an average high of 3.25 contacts per week. Some records showed many contacts within groups or in individual counseling with non-ACT staff.	• When conditions allow, provide members an average of four in person contacts with staff per week. Frequency of contact may vary member to member, week to week, depending on immediate and emerging needs. • Avoid over-reliance on groups to achieve contact. • ACT members should receive services from ACT staff.
S6	Work with Support System	1 – 5 3	Staff report that 52 members have a natural support but that not all have signed an ROI. Staff said that the team attempts to establish contact with a natural support once a week, either by email or phone calls. Three of ten records reviewed showed evidence of contacts with natural supports, with average contacts calculated at 1.40 in a week period. Some contacts occurred during home visits and scheduled office visits with the Nurse and Psychiatrist. Other records showed natural supports reaching out to staff for assistance during crisis or inquiring about member needs or well-being, while others showed outreach toward natural supports by the ACT team. Several member treatment plans reviewed identified natural supports.	• Increase contacts with informal supports to an average of four per month for each member with a support system. As much as possible, contacts with informal supports should occur during the natural course of delivery of services provided to members. • The team should consider monitoring their documentation of contacts with informal supports. Some teams review these contacts during the program meeting.

S7	Individualized Substance Abuse Treatment	1 – 5 4	The team provides individual substance use treatment to members with a Co-Occurring Diagnosis (COD). Staff report approximately 30 out of 39 members with a COD receive a weekly individual contact to engage in substance use treatment. Staff report a typical session is 23 minutes. Staff report even though some members decline services, they continue to offer individual substance use treatment services. Staff report to meeting members in person, by phone, as well as offering Zoom sessions, however, no members report to have Zoom capability. Staff have assisted members in securing Zoom capable phones but report a lack of data capability to support the application.	• All ACT team staff should engage members with a substance use diagnosis to participate in regularly occurring individual substance use treatment with ACT staff. An average of 24 minutes or more of formal structured individual substance use treatment should be provided weekly across all members with a co-occurring disorder.
S8	Co-occurring Disorder Treatment Groups	1 – 5 1	Staff interviewed reported to be offering substance use treatment groups via Zoom two days a week, however, stated that none of the members with a COD have zoom capability. Staff report that at the time of the review, it was company policy that in-person groups could not be provided due to the risk of spread relating to the public health emergency. Staff expressed concern for the members on the team living alone in isolation as well as those fearful of leaving their residences due to the public health emergency. Staff stated that clients are asking about their peers and look forward to the socialization and non-judgmental atmosphere. Staff report several members are anxiously waiting to restart groups. When the office was able to open up, briefly, one group was held, and six members attended.	• All ACT staff should engage members diagnosed with a co-occurring diagnosis to participate in treatment groups based on their stage of change. Optimally, at least 50% of members diagnosed with a COD attend at least one treatment group monthly. • Consider alternative delivery options of group services to members. Some teams offer phone groups, others provide maximum capacity groups with adequate space, mandatory masks, and screenings to reduce potential spread and to follow public health guidance. Utilize resources through other agency ACT teams to gain input to develop a solution to providing members group treatment. Offering a group that members cannot access is not a valid option.

				• When planning to reopen in person groups, or offering more than one group, consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Based on interviews with staff and observation of the team meeting, staff are familiar with stages of change and reported the stage of change for some members during the meeting observed. Staff did not appear to be as familiar with stage-wise treatment interventions. One staff interviewed stated that the team would like to see complete sobriety for members. Training records showed that some staff participated in Integrated Dual Disorder Treatment (IDDT) training modules. Staff reported that the team uses IDDT which was referenced during the program meeting. The team will refer members to detoxification when medically necessary. Review of records showed use of traditional language, i.e., clean, sober. Goals were not stated in terms of the member's goal, rather tasks the member or staff must complete. Although one staff completed training on the efficacy of Medication Assisted Treatment, one record reviewed minimized the value of the treatment and staff persuaded the member to try alternative measures to treat their addiction. The SASs and another specialist had numerous hours of training in Motivational Interviewing.	• Provide all specialists with ongoing training and mentoring in the principles of the co-occurring model/stage-wise approach. Training should include how to align treatment interventions to the stage of recovery (change) identified, as well as Motivational Interviewing. Discuss client's stages in the program meeting to bring awareness to the team as they all work to engage with the clients about their goals around recovery. Relias has many of these trainings available. • Use recovery language in member documentation of services and plans. Ensure member treatment plans are in member's voice and that members themselves understand that abstinence does not necessarily need to be their goal when addressing substance use. • Provide Motivational Interviewing training for all ACT team staff to support clients to identify their recovery goals and engage in services.

S10	Role of Consumers on Treatment Team	1 – 5 2	Staff reported that the team has staff with lived experience of recovery, although it was not clear if it is psychiatric recovery. Two staff interviewed indicated there was no one on the team with lived psychiatric experience. The reviewers were told that the Peer Support Specialist (PSS) position is currently vacant; one staff suggested that the position should be divided between two part-time staff due to the intense and stressful nature of the job. Two members interviewed were not aware of any staff with lived experience.	• Fill the vacant PSS position. PSSs have specialized training and provide a valuable service to clients, client families, and bring a unique perspective to the clinical team. PSSs provide expertise about symptom management and the recovery process; promote a team culture that supports client choice and self-determination; share their story of recovery and practical experience; and carry out other rehabilitation and support functions of the team.
Total Score:		110		

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	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	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	3
6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	2
Total Score	3.93	
Highest Possible Score	**5**	