ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Dr. Karen Hoffman Tepper, Chief Executive Officer
Sandra Mendoza, Clinical Coordinator

From: Allison Treu, AS
Vanessa Gonzalez, BA
AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with Western Interstate Commission for Higher Education Behavioral Health Program to conduct Fidelity Reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an evidence-based practice (EBP).

Method

On January 10 – 11, 2023, Fidelity Reviewers completed a review of the Terros Health Priest 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.

Terros Health provides services for persons diagnosed with a serious mental illness (SMI) at several locations in the Central Region of Arizona. There are a total of four ACT teams located among three clinics. This review will focus on the ACT Team located at Priest Health Center.

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

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to interview staff and members.

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

- Remote observation of an ACT team program meeting on January 10, 2023.

- Individual video conference interview with the Clinical Coordinator.
- Individual video conference interviews with the Co-Occurring Specialist, Housing Specialist, ACT Specialist, and Peer Support Specialist.
- Individual phone interviews with three members participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care RBHA ACT Operational Manual (2018)*, *Mercy Care ACT Admission Criteria*; Clinical Coordinator productivity report, resumes and training records for Vocational staff and Co-Occurring Specialists' staff, *member calendars*, sign in sheets for Substance Use treatment groups for the month prior to the review, cover sheet for *TERROS L.A.D.D.E.R Recovery Group Manual* and *National Council for Mental Wellbeing -Team Solutions and Solutions for Wellness,* ACT team member roster identifying members with a co-occurring disorder and members with a natural support, ACT Team Welcome Packet, ACT Directory.

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 review. A copy of the completed scale with comments is included as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team is of sufficient size to provide the necessary coverage to the 94 members served for a member to staff ratio of 9:1.
- The team, including the Psychiatrist, meets four days a week to discuss members. During the meeting observed, multiple staff contributed to the meeting discussion by reporting on recent and planned contacts with members.
- The ACT team has two fully dedicated Nurses and two fully dedicated Co-Occurring Specialists assigned to work with members of the ACT team.
- In the past 12 months, this team has maintained consistency and continuity of care for members, as evidenced by maintaining low admission and drop-out rates.

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

- Provide regular training and guidance to vocational staff related to supports and best practices that aid members to obtain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, and follow-along supports. ACT vocational staff should directly provide the full range of employment services.
- Increase the frequency and intensity of services delivered to members. ACT services should be responsive to member needs, adjusting in intensity and frequency as it relates to members' individual needs and preferences. Higher frequency of contact correlates to improved outcomes for ACT members.

- Increase engagement with natural supports. Natural supports should be aware of the services the team offers so they can reach out when members require additional support, such as when 24-hour services may be utilized, or hospitalization may be required.
- Provide ongoing training to all staff on an evidence-based practice for persons with a co-occurring disorder diagnosis.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 94 members with 10 staff that provide direct services, excluding the Psychiatrist and administrative staff, resulting in a member to staff ratio of 9:1. Full-time direct staff included the Clinical Coordinator (CC), two Nurses, two Co-Occurring Specialists (COS), the Housing Specialist, Rehabilitation Specialist, Independent Living Specialist, ACT Specialist, and Peer Support Specialist. At the time of the review, the ACT Counselor and Employment Specialist positions were vacant.	
H2	Team Approach	1 – 5 4	Staff interviewed reported 80% of members have contact with at least two ACT staff each week. Staff reported following a weekly zone rotation to ensure all members have in-person contact with more than one staff over a two-week period. Staff report tracking engagement efforts on member calendars. The ACT team provides members with a calendar that includes which staff are assigned to their geographic area for the week. Based on review of ten randomly selected member records, 80% received in-person contact with more than one staff in a two-week period. All members interviewed reported seeing more than one team staff during the prior week.	• Ideally, 90% of ACT members have contact with more than one staff in a two-week period. Consider options to increase contact to members according to the goals identified in individual service plans. • Continue efforts to ensure all members on the ACT roster have in-person contact with more than one staff in two weeks; a diversity of staff allows members access to unique perspectives and the expertise of staff.
H3	Program Meeting	1 – 5 5	Staff interviewed reported all staff, including the Psychiatrist and Nurses meet four days a week and all members on the roster are reviewed.	

			During the program meeting observed, the CC led the meeting and staff contributed updates on recent engagement, missed appointments, medication observations, group attendance, employment goals, hospitalizations, jail visits, housing needs, and contact with natural supports or formal supports. The CC assigned outreach strategies and identified member treatment needs.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimated delivering 10 hours of in-person services to members each week. The CC reported providing case management, medication observation, independent living skills, hospital discharges, and medication education to members of the ACT team. Three of ten member records reviewed showed the CC providing direct services in the community and at the clinic. Based on the CC's productivity report for a recent period, the CC delivered 8.75 hours per week of direct in-person services to ACT team members.	• Continue efforts to provide in-person services to members 50% or more of the expected productivity of other ACT staff.
H5	Continuity of Staffing	1 – 5 4	Based on data provided, four staff left the team since the previous review (November 2021), resulting in a turnover rate of 31%. Per data provided, ACT Counselor and Employment Specialist were the most difficult to retain.	• Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their supports. • Continue efforts to recruit and retain experienced staff. Support staff in their specialty roles by ensuring they receive training and guidance applicable to their specialty position.
H6	Staff Capacity	1 – 5 4	Per data provided and reviewed with staff, the ACT team had 27 vacancies in the 12 months prior to the review and operated at approximately 81%	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible.

			staffing capacity. Two positions were vacant at the time of the review.	Timely filling of vacant positions also helps to reduce potential burden on staff.
H7	Psychiatrist on Team	1 – 5 5	The team has one Psychiatrist that works four 10-hour days Tuesday - Friday and attends the program meeting on those days. Staff reported the Psychiatrist is fully dedicated to members of this ACT team and is accessible to the team in-person, by phone, and email, including after hours and weekends. Staff reported the Psychiatrist provides services at the clinic, at member homes, and to members while hospitalized. Per review of ten records, the Psychiatrist provided direct service to six members in the month period reviewed.	
H8	Nurse on Team	1 – 5 5	The ACT team has two Nurses assigned to work with members of the team. Both Nurses attend all program meetings. One Nurse provides services in the community and attends specialist appointments with members when needed. The other Nurse works primarily in the office to provide care for members and is the Lead Nurse for the clinic. Staff interviewed reported the Lead Nurse supervises clinic medical assistants and coordinates coverage for non-ACT team Nurses; however, additional duties do not affect team coverage and the Lead Nurse does not see members outside of this ACT team. Staff reported the Nurses are readily accessible to the team by phone, email, and in-person and are available after hours. Nurses provide medication education, administer injections, complete lab draws, triage members in crisis, primary care physician coordination, and inpatient hospital staff coordination.	

H9	Co-Occurring Specialist on Team	1 – 5 4	The team is staffed with two COS. One has been on the ACT team for nearly 12 months and has previous experience delivering substance use treatment services. This COS completed at least one training related to substance use, per documents provided. Per staff interviews, the COS is provided group supervision by the Clinical Director, a Licensed Associate Counselor. The second COS joined the team one week prior to the review and did not appear, per resume, to have previous experience providing substance use treatment services.	• Provide annual training to Co-Occurring Specialists in co-occurring treatment best practices, including appropriate interventions, i.e., stage wise approach, based on members' stage of change. • Continue to provide COS with supervision and guidance in co-occurring treatment best practices. Optimally, consistent evidence-based co-occurring treatment information is provided and then disseminated, through cross training, to other ACT staff.
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has one Vocational staff. The Rehabilitation Specialist has more than three years' experience on the team assisting members to identify needs and connect with resources in their community. Training records provided showed one training related to employment completed in the last 12 months.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Ensure that both vocational staff receive ongoing training in assisting people diagnosed with SMI/co-occurring diagnoses to find and retain competitive employment. Training should include techniques to engage members to consider employment; job development strategies; the importance of supporting in-person employer contact soon after members express an employment goal; and the provision of follow-along supports to employed members.
H11	Program Size	1 – 5 5	At the time of the review, the ACT team had 11 staff including the Psychiatrist. The team is of adequate size to provide coverage to 94 members.	
O1	Explicit Admission Criteria	1 – 5	The ACT team has a clearly defined target population. Based on interviews with staff, the	

		5	team utilizes the *Mercy Care ACT Admission Criteria* and a screening check list to assess potential admissions. Staff interviewed identified admission criteria and reported that new referrals are referred by agency supportive teams, the Regional Behavioral Health Authority (RBHA), hospitals, guardians, and ACT to ACT transfers. When new referrals are received, the CC coordinates with the referring agency and that team's Psychiatrist and will then discuss the findings with the ACT team. The ACT Psychiatrist makes the final decision when the member is appropriate for the team. Staff interviewed reported circumstances when the team felt pressured to accept ACT to ACT interagency transfers.	
O2	Intake Rate	1 – 5 5	Per the data provided, and reviewed with staff, the ACT team admitted eight members in the last six months prior to the review, with the highest number of three new members admitted in the month of July. This rate of admission is appropriate.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management services, the ACT team directly provides psychiatric services and medication management, most housing support, and substance use treatment. The team has two members that reside in settings where there is a duplication of ACT services. Reviewers were informed that staffings are held at 30 days to determine if members will continue at that level of care, and the potential of transferring to a supportive team. Staff interviewed indicated all staff will provide counseling to ACT team members when needed,	• ACT staff should first engage directly with members to support rehabilitation and competitive employment goals rather than refer to outside resources. Offer individualized engagement and assistance. • Counseling/psychotherapy should be available to members on ACT teams provided by ACT staff. Consider options to include staff on the team that are qualified to provide individual counseling to members.

			but do not have a licensed professional on the team. One member interviewed reported receiving counseling services from a non-ACT team staff and three member records reviewed documented staff referring members for counseling off the team. Relating to employment supports, there are 12 members on the team that are participating in a work adjustment program (WAT) off the ACT team.	
O4	Responsibility for Crisis Services	1 – 5 5	Per interviews with staff, the team provides 24-hour crisis services to members. Staff rotate on-call responsibilities weekly; medical staff are not included in the rotation. The CC serves as the back-up to staff on-call. Staff indicated the team will assess the member situation by phone, attempt to deescalate, and when needed, meet the member or emergency services in the community at any hour. Members are provided the *Terros Priest Welcome Packet* during on boarding to the team which includes the ACT on-call number along with all ACT team staff contact information. Members are also given an *ACT Directory* handout with ACT on call numbers, staff roles, and contact numbers. Two members interviewed reported awareness of the on-call number and 24-hour services available from the team; however, one member was not aware of the services available.	• Ensure staff educates members and their supports of the teams on-call availability, including staff response in the community, if needed.
O5	Responsibility for Hospital Admissions	1 - 5 4	Staff interviewed reported the team is directly involved in member psychiatric hospital admissions. The team engages with all members when experiencing an increase in symptoms that may require inpatient care by triaging the	• 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

			member's needs and coordinate with the CC and the ACT Psychiatrist for next steps. After staffing with the Psychiatrist, when it is determined that inpatient treatment is needed, the team will transport the member to the hospital, supporting the member until they are admitted. Of the ten most recent member psychiatric hospital admissions that occurred over a five-month period, the team was directly involved in 70% of admissions. One record indicated the member self-admitted, and two records showed members were taken to hospital by law enforcement.	psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build rapport with natural supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff interviewed reported that the team is directly involved in 100% of psychiatric discharges. Staff reported picking up members at the hospital, receiving discharge paperwork, helping with filling prescriptions, transporting home, completing a home safety check, and providing information about upcoming appointments. The member is scheduled with the team's Psychiatrist and Nurse within 48 hours of discharge and a Primary Care Physician appointment within 30 days. The team follows a five-day follow-up protocol which includes in-person contact each day following discharge. Per the data provided, and reviewed with staff, the ten most recent hospital discharges occurred over the past two months prior to the review. Of the data provided, the team was directly involved in all ten. Although, one member record reviewed that was not included in the data provided showed staff transporting the member home after	• Ensure the team delivers post psychiatric hospital follow up services and supports as described during interviews.

			discharge, however, did not meet with the Psychiatrist or Nurse until seven days later. The record lacked documentation of the team attempting to reach out to the member until three days after the provider appointment.	
O7	Time-unlimited Services	1 – 5 5	Based on staff interviews, members can request to step-down from the ACT team. If a member is showing significant improvement, the team will discuss member goals and engage the member in discussions about stepping down from the ACT team. Graduation is based on member choice. Per the data provided to reviewers, the ACT team graduated one member in the last year. Staff interviewed reported that the team anticipates graduating one member in the next 12 months.	
S1	Community-based Services	1 – 5 4	Staff interviewed reported that 70% - 80% of in-person contacts with members occur in the community. Per review of ten randomly selected member records, the ACT team provided services a median of 70% of the time in the community. Four of the ten charts reviewed showed 80 – 100% of contacts with members were in the community for a month period reviewed which included at members' residences, grocery stores, convenience stores, and on a public street. Members interviewed reported receiving service at their homes or at the clinic.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. • When new group activities are developed, avoid reliance on the clinic as the location of that activity.
S2	No Drop-out Policy	1 – 5 5	According to data provided, a total of three members dropped out of programming with the team resulting in 97% retention rate in the last 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff interviewed reported at the time of the review approximately 20% of members were on outreach. Most members can be re-engaged in services within eight weeks, outreaching four	• When members miss scheduled appointments or are not seen at the frequency of ACT services, ensure a team discussion occurs during the

			times a week. Staff reported following the *Mercy Care RBHA ACT Operational Manual (2018)* outreach guidelines. Staff efforts to engage include phone calls to family members, probation officers, shelters, hospitals, and checking the Medical Examiner's Office. The team completes physical outreach attempts to known addresses, areas members are known to frequent, parks, and gas stations in the community. Staff interviewed reported additional methods to keep members engaged include frequent home visits, engaging in groups, helping members with immediate needs like food, clothing, hygiene supplies, and ensuring members are engaged by all team staff. The team uses member calendars to track outreach attempts and develop member engagement strategies. During the program meeting observed, staff provided updates on recent attempts to engage members, updated the team on missed appointments with Psychiatrist and Nurses, and the CC directed next steps to staff for outreach attempts. Records review showed four member records with outreach and engagement attempts spanning 8 – 16 days in-between attempts. One member missed a provider appointment, yet staff did not follow up until nine days later.	program meeting to plan follow up care and is documented in member records. • Ensure the team is assisting members in working on their recovery goals as identified. By using Motivational Interviewing and other techniques, the team can assist members in identifying meaningful recovery goals and offer the supports and services for members to reach those goals. Goals may change frequently for those members not engaged in recovery, but it is important for the team to adjust their services to meet the member's needs regardless.
S4	Intensity of Services	1 – 5 2	Ten randomly sampled member records showed, the median amount of time the team spent in-person with members was 44.63 minutes weekly. The record with the highest average weekly intensity of in-person services was 225.25	• The ACT team should provide members an average of 2 or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average

			minutes. The record with the lowest average weekly intensity of in-person services was 18.50 minutes. The median amount of time spent delivering phone services was about 3 minutes. The median phone contact was one per member. Several member records included documentation of service delivery which was identical to documentation in other member records providing no personal information relating to the members. *The fidelity tool does not accommodate delivery of telehealth services.*	service time delivered. Ensure services are accurately documented. • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. Documented service time is significantly higher for some members, than others. • Ensure staff are trained on appropriate documentation standards to ensure that services delivered are appropriately reflected in the members' medical records.
S5	Frequency of Contact	1 – 5 2	Of the ten records randomly sampled, ACT staff provided in-person contacts across all members for a median frequency of 1.63 contacts per week. The highest member record reviewed indicated an average frequency of 5.25 in-person contacts a week. Eight of the ten records reviewed received 1.75 or less in-person contacts per week.	• Optimally, ACT members receive an average of 4 or more in-person contacts a week. The number of contacts may vary, with some members receiving fewer and others receiving more contact depending on immediate and emerging needs. • Seek to balance services delivered to more frequently contacted members and those that staff meet with less often.
S6	Work with Support System	1 – 5 1	Per data provided, 62 members were identified as having a natural support. Staff interviewed reported weekly attempts to engage natural supports by phone, email, or in-person during home visits to members that live with natural supports. Staff reported tracking contact with natural supports during program meetings on member calendars.	• Ensure consistent documentation of contacts with natural supports occurs, which include updating releases of information, documenting contacts by phone, email, and text. The ACT team should have four or more contacts per month for each member with a community support system. • Ensure that all natural support contacts are documented in member

			Based on the ten member records reviewed, there were .20 average team contacts with supports per the month period reviewed. One record showed that team staff was unable to share information with a natural support, identified by the member as a support, due to unknown status of a current release of information. Review of ten-member show no current natural support releases signed.	records and releases are updated regularly. • Educate members and natural supports on the benefits of collaboration to support members' recovery goals. Some ACT teams describe the PSS as a significant contributor to this effort.
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 2	Per data provided, and staff confirmation, 48 members of the ACT team have a Co-Occurring Disorder (COD) diagnosis. Per interviews with staff, 27 members are participating in 30 minutes per week of structured individualized substance use treatment provided by the COS. *Member calendars* provided showed few members (eight) receiving individualized substance use treatment. However, it was unclear if these were formalized through structured appointments, or if the service was in addition to a routine home visit. Sessions documented ranged from 6 – 30 minutes. Of the records reviewed, five members were identified as having a COD. No member records had documentation of individual sessions provided.	• Work to increase the time spent in individual sessions and increase the number of members engaged so that the average time is 24 minutes or more per week across the group of members with co-occurring diagnoses. • Monitor member participation in individualized substance use treatment through the COS to gauge duration and frequency. • ACT staff should offer and document individual treatment to members with co-occurring diagnoses and document if the member chooses not to engage in scheduled structured appointments.
S8	Co-Occurring Disorder Treatment Groups	1 – 5 3	Staff interviewed reported the ACT teams offers substance use treatment groups twice weekly for assigned ACT team members with a COD. Staff reported the curriculum used to structure groups is based on the *National Council for Mental Wellbeing Team Solutions and Solutions for Wellness,* and *TERROS L.A.D.D.E.R Recovery Program Manual.* Staff reported 17 unique members participate in groups monthly, and	• Optimally, 50% or more of members with a substance use disorder attend at last one COD treatment group each month. All ACT staff should engage members with a COD diagnosis to participate in treatment groups based on their stage of change with content reflecting stage-wise treatment approaches.

			groups range from three to seven members attending weekly. Sign in sheets provided for a month period before the review showed all members attending the substance use treatment groups are ACT team members, however, not all members attending were listed by the team as having a COD. Of the records reviewed, five members were identified as having a COD. Only one member record showed documented group attendance; however, the treatment plan did not reflect goals related to substance use treatment. Two records documented discussion of attending groups. In one record the member expressed a desire to attend, and another record showed the member was medically unable to attend office-based groups. Yet, no further documentation was seen of the ACT team efforts to support either member.	
S9	Co-Occurring Disorders Model	1 – 5 3	Most ACT staff interviewed appeared familiar with the stages of change. During the program meeting observed, not all member's stage of change was identified. Staff report supporting members with motivational interviewing and provided examples of harm reduction tactics utilized. The team reported using a person-centered approach that emphasizes harm reduction as their focus and an individualized approach for all members, rather than expecting abstinence. However, at least one staff reported abstinence is the goal. When members request detoxification services or a referral to peer run organizations outside the ACT team, the team will support the member and refer them to local resources.	● Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Treatment for Co-Occurring Disorders, in the principles of stage-wise treatment, and motivational interviewing. ● Ensure member treatment plans include goals related to recovery, steps they intend to take, and roles the ACT team will take to support the member. Include individual and group substance use treatment, as well as other supports members identify.

			Of the five member records identified with a COD, two had treatment plans listing substance use treatment as an intervention provided by the team. For those two, records showed staff, other than COS, supporting members to explore recovery by using motivational interviewing techniques and encouraging groups. The other member records did not have COD services listed in the treatment plans, nor was there documentation of supports provided. Staff reported receiving monthly trainings on COD. However, training records provided did not show evidence of training in treating co-occurring disorders, motivational interviewing, or the stage-wise approach to substance use treatment.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has at least one staff with lived psychiatric experience on the team that shares the same responsibilities as other ACT staff and have equal status on the team. Members interviewed were aware of staff with lived psychiatric experience on the team and reported that team staff have shared their personal stories of recovery.	
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	4
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Co-Occurring 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

	Rating Range	Score (1-5)
5. Responsibility for Hospital Admissions	1-5	4
6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	2
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	**3.93**	
Highest Possible Score	**5**	