ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with the 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 July 22 – 24, 2024, Fidelity Reviewers completed a review of the Terros Health - 23rd Avenue Health Center ACT 1 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 a range of services, including primary medical care, behavioral health, and substance use treatment. The agency operates several centers in the Central Region of Arizona which includes four ACT teams. This review specifically focuses on the 23rd Avenue Health Center ACT 1 team. The individuals served through the agency are referred to as *clients* or *members,* but for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

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 observe meetings, and to interview staff and members.

During the fidelity review, reviewers participated in the following:

- Remote observation of an ACT team program meeting on July 23, 2024.

- Individual videoconference interview with the Clinical Coordinator.
- Individual phone interview with the Employment Specialist.
- Individual videoconference interview with the Peer Support Specialist.
- Group videoconference interview with the Co-Occurring Disorders Specialists.
- Group phone interview with the ACT Specialist and Independent Living Specialist.
- Individual phone interviews with five members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, ACT Program Analyst, and representatives from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Terros Health- Meet Your ACT TEAM* handout; Clinical Coordinator productivity report; *Outreach* document; *Mercy Care ACT Admission Criteria*; copies of cover pages of substance use disorder treatment materials utilized; co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and Co-Occurring Disorders Specialist staff; and Co-Occurring Disorders Specialists monthly calendar.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a 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 with little room for improvement*).

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

<u>Summary & Key Recommendations</u>

The agency demonstrated strengths in the following program areas:

- The team has two Nurses, a fully dedicated Psychiatrist, and two fully dedicated Co-Occurring Disorders Specialists assigned to work with members.
- The team meets a minimum of four days a week to discuss all members. All staff including the Psychiatrist attend program meetings on the days they are scheduled to work.
- The team provides crisis support coverage by phone and in the community after business hours and weekends.
- The team was involved in 80% of the ten most recent psychiatric hospital admissions and 90% of the ten most recent psychiatric hospital discharges.
- The team values engaging with members' natural supports by offering supportive listening, providing community resources, and facilitating a family support group led by the ACT team Peer Support Specialist twice a month.

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

- Increase contact of diverse staff with members. The team approach of ACT ensures continuity of care for members and creates a supportive environment for staff, potentially reducing the burden of responsibility for member care.
- Increase support for members that receive a lower intensity and frequency of service. ACT teams provide members with an average of two (2) or more hours of in-person service delivery and an average of four (4) or more in-person contacts weekly. ACT services are best provided in the community where challenges are more likely to occur and where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting at least 80% of the time.
- There is limited involvement by members in individual and co-occurring disorders group treatment provided by the team. Increase the engagement and participation of members in substance use treatment services. The entire ACT team is responsible for engaging members in substance use treatment services.
- Provide ongoing training and clinical oversight to the team pertaining to a co-occurring disorders treatment model. Committing to an evidence-based practice framework such as the Integrated Co-occurring Treatment Disorders Model would provide all ACT team staff with a shared understanding of co-occurring disorders principles.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The ACT team serves 95 members with nine full-time equivalent (FTE) direct service staff, excluding the Psychiatrist and administrative staff. The team has a member to staff ratio of approximately 11:1. Staff on the team include the Clinical Coordinator, Employment Specialist, Peer Support Specialist, ACT Specialist, Independent Living Specialist, two Co-Occurring Disorders Specialists, and two Nurses.	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 - 5 2	Staff reported that over a two-week period, 80% of members interact with more than one ACT staff. Each staff is assigned a caseload of about 12 members and is responsible for meeting with assigned members four times a week. The team rotates outreach and hospital visits among all staff members on a weekly basis. Additionally, roughly 21 members receive daily medication observation managed by specialists on a rotating schedule. Staff engage with members outside of their assigned caseload when a member needs to see a specific specialist, or when members attend clinic appointments or ACT group sessions. The ten randomly selected member records reviewed, for a month period, show a median of 30% of members received in-person contact from more than one staff from the team in a two-week period.	• Ideally, 90% of ACT members have in-person contact with more than one staff in a two-week period. Consider eliminating member assignments. The team approach of ACT ensures continuity of care for members and creates a supportive environment for staff, potentially reducing the burden of responsibility. ACT staff are cross trained to work as a transdisciplinary team rather than individual case managers. Further, ACT team staff collaborate on assessments, treatment planning, and day-to-day interventions. • Consider one strategy utilized by other teams by assigning geographic areas that rotate daily or weekly to ensure members are engaging with diverse staff from the team frequently.

H3	Program Meeting	1 - 5 5	Per interviews with staff, the team meets at a minimum four days a week and reviews all members. All staff including the Psychiatrist attend the meetings on the days they are scheduled to work. During the program meeting observed, the Clinical Coordinator led the discussion utilizing member calendars. The meeting included reviewing missed appointments, updates on recent member interactions, member's stage of change, outreach attempts, individual service needs, natural support contact, and planned contact for the day.	
H4	Practicing ACT Leader	1 - 5 2	At the time of the review, the Clinical Coordinator recently began carrying a caseload due to recent staff vacancies. It was estimated that delivery of in-person services to members averaged seven hours per week. Reported activities include home visits, hospital visits, and completing medication observation and education. Productivity expectation for in-person service delivery for team staff is 30 hours weekly. Based on the productivity report for a four-week period, the Clinical Coordinator provided direct services 7% of the expected productivity of other ACT staff. There were five examples of the Clinical Coordinator delivering direct services to members at the clinic and four examples in the community of the ten member records reviewed.	• Optimally, the ACT Clinical Coordinator delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff. Increase in-person member contact. Practicing ACT leaders can engage in a range of member care needs including providing counseling/psychotherapy, facilitating or co-facilitating co-occurring disorders treatment groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffings, shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery.

			This item is dependent on the Provider productivity expectation.	
H5	Continuity of Staffing	1 - 5 4	Based on information provided, and reviewed with staff, the team experienced turnover of 38% over the past two years. The positions with the highest turnover were the Co-Occurring Disorders Specialist and Peer Support Specialist.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff. • Continue efforts to recruit and retain experienced staff. Support staff in their specialty roles by ensuring training and guidance applicable to the specialty position is provided.
H6	Staff Capacity	1 - 5 4	In the past 12 months, the team operated at 93% of full staffing capacity. The Co-Occurring Disorders Specialist position was vacant for seven months.	• Continue efforts to retain qualified staff with the goal of operating at 95%, or more, of full staffing annually.
H7	Psychiatrist on Team	1 - 5 5	The team has one FTE Psychiatrist that works four, ten-hour days. Staff interviewed reported the Psychiatrist provides services to members in-person at the clinic and is assigned one day in the community. The Psychiatrist is accessible to the team in person, by phone, and email, including after hours and weekends. Members interviewed reported meeting with the team Psychiatrist at least once a month, either in person at the clinic or at their home. Per records, the Psychiatrist provided direct service to nine members at the clinic during the period reviewed.	
H8	Nurse on Team	1 - 5 5	The team has two Nurses assigned to work with the members of the team. The Nurses' schedules are staggered, and both attend the program meeting on their assigned workdays. Nurses are readily available to the team, including after	

			hours and on weekends. Each Nurse is assigned one day a week to provide services to members in the community. Per review of records, the Nurses provided direct in-person services at the clinic to seven members in the month period reviewed. Members interviewed reported seeing the Nurses weekly to monthly.	
H9	Co-Occurring Disorders Specialist on Team	1 - 5 4	The team is staffed with two Co-Occurring Disorders Specialists. One Co-Occurring Disorders Specialist recently rejoined the team in June 2024 and has several years of experience providing substance use treatment services. Training records provided showed this staff having completed *Stages of Change and Motivational Interviewing* in the past two years. The second Co-Occurring Disorders Specialist joined the team in January 2024 and brings experience in supporting individuals with mental health and substance use challenges within the community. According to the training records provided, no co-occurring disorders-related training has been completed in the past two years. The Co-Occurring Disorders Specialists do not receive regular clinical supervision from a qualified professional relating to providing services to individuals with co-occurring disorders.	• Provide annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. On ACT teams, Co-Occurring Disorders Specialists have the capability to cross-train other staff, providing guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model utilized by the team. • Ensure Co-Occurring Disorders Specialist staff are provided with regular supervision, ideally from a qualified professional.

H10	Vocational Specialist on Team	1 - 5 3	The team has one Vocational Specialist providing services to members. The Employment Specialist has been working with members of this team since February 2020. Training records provided show one vocational-related training completed in the past two years. The team's Rehabilitation Specialist left the team the week prior to the review.	• ACT teams maintain two full-time Vocational Specialist staff with at least one year of experience providing employment supports. • Ensure that vocational staff receive ongoing training in assisting people diagnosed with serious mental illness/co-occurring disorders diagnoses to find and retain competitive employment.
H11	Program Size	1 - 5 5	At the time of the review, the team was composed of ten staff including the Psychiatrist. The team is of sufficient size to provide staffing diversity and coverage for members of the team. There were two vacant positions: the Rehabilitation Specialist and the Housing Specialist.	
O1	Explicit Admission Criteria	1 - 5 5	The team utilizes the *Mercy Care ACT Admission Criteria* screening tool to assess potential members for admission. New referrals are received from the local contractor with a Regional Behavioral Health Agreement, teams within the agency, and other provider network organizations. The Clinical Coordinator and Psychiatrist review the member packet, followed by a doctor-to-doctor consultation from the referring entity. The Clinical Coordinator, along with two other ACT staff members, is trained to conduct screenings with potential members either at the clinic or in the community. The final decision on admission to the team is made by the Clinical Coordinator and Psychiatrist, based on the screening results and the member's agreement to the level of ACT services. The team reported	

			that there is no pressure to admit members to the team.	
O2	Intake Rate	1 - 5 5	Based on the data provided, and reviewed with staff, the team has an appropriate admissions rate. The months with the highest admission rate during six months prior to the review were February and June with two new members added to the team roster.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management, the team provides psychiatric and medication management services, housing support, co-occurring disorders treatment, and employment and rehabilitative services. All members interviewed reported services they receive are only provided by the ACT team. At the time of the review, no members were receiving psychotherapy or counseling from the ACT team or from brokered providers. The team currently lacks the qualified staff needed to offer these services and reportedly are not referring members out for these supportive services.	• Counseling/psychotherapy is made available to members on ACT teams and is provided by ACT staff. This staff will also act as a generalist within the team. Consider options to include staff on the team that are qualified to provide individual counseling to members. • When an ACT team does not have the resources to provide the services members need, referrals are made to outside entities to ensure the services are available to the member to support recovery.
O4	Responsibility for Crisis Services	1 - 5 5	Based on interviews, the team provides crisis services to members 24 hours a day, seven days a week. Staff rotate on-call responsibilities weekly, with a second staff assigned as back-up to the on-call staff. When calls are received, staff attempt to de-escalate by phone and will meet in the community when needed. Reviewers were provided a copy of the *Terros Health- Meet Your ACT TEAM* handout that is provided to members. The handout identifies the clinic, on-call phone numbers, staff phone numbers, and brief descriptions of each staff	

			role on the team. Four of the five members interviewed were knowledgeable of the after-hours services available to them from the team.	
O5	Responsibility for Hospital Admissions	1 - 5 4	During business hours, staff address safety and stabilization concerns by bringing members to the clinic for evaluation by a Nurse and Psychiatrist to determine next steps. After hours, on-call staff assess situations by phone to determine the need for inpatient stabilization. Staff consult with the Psychiatrist for a final decision. When inpatient care is necessary, the staff either transports the member to the facility and stays through the admission process or arranges transportation via a portal when the distance is considerable. Staff coordinate with the inpatient team providing relevant information including medication details and the most recent psychiatric note. Based on data provided and reviewed with staff, the ACT team was directly involved in 80% of the most recent psychiatric hospital admissions that occurred over a two-month period. One member hospitalization documented was not included in the provided data, for that admission the team amended the member's court ordered treatment for inpatient stabilization. For admissions in which the team was not involved, two members self-admitted without reaching out to the team.	• ACT teams performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. • 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 a rapport with natural supports.
O6	Responsibility for Hospital Discharge Planning	1 - 5 4	Staff reported that discharge planning starts within 24 hours of admission. The team rotates hospital member visit responsibilities which are conducted on Mondays, Wednesdays, and Fridays. In-person or videoconference meetings	• Ideally, ACT teams are directly involved in 95% or more of psychiatric discharges. • Consider peer review of documentation to ensure services are accurately included in member records.

			with the inpatient team are held at least once a week to discuss discharge plans. A doctor-to-doctor consultation between the team psychiatrist and the inpatient provider takes place shortly after admission. Upon discharge, staff meet members at the hospital, transport them to the clinic to review: discharge paperwork, current medications, and to ensure that bubble packs are accurate for medication monitoring. Members are then transported to their chosen location. Follow-up appointments with the Psychiatrist are scheduled within 72 hours of discharge, and appointments with a Nurse and primary care physician are also arranged. For the first five days post-discharge, staff meet with members either in the clinic or within the community. A review of data for the ten most recent psychiatric hospital discharges over a two-month period showed the team was directly involved in 90% of the cases. One member hospitalization documented was not included in the provided data. The record showed doctor-to-doctor coordination two days after admission but did not indicate any other team involvement while the member was inpatient or during discharge.	
O7	Time-unlimited Services	1 - 5 5	Data provided showed one member graduated from the team with significant improvement in the past 12 months.	
S1	Community-based Services	1 - 5 3	Staff interviewed reported 75 – 80% of in-person contacts with members occur in the community. Staff reported approximately 21 members of the	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur

			team are provided medication observation services at members place of residence, most occur twice a day. Four of the five members interviewed receive medication observation daily by team staff at their residences, including weekends. A review of ten randomly selected member records revealed that staff provide services in the community a median of 45% of the time. Documented community services include home visits, medication management and delivery, and transportation to explore housing options.	in members' communities where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1 - 5 5	According to data provided and reviewed with staff, the team had four members that dropped out of the program in the past year. The team retained 96% of the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 - 5 3	Staff interviewed reported that the team makes a minimum of four attempts each week for at least eight weeks to reconnect with members who have lost contact with the team. At least two of these attempts are made in the community and two electronic outreach attempts which can be by phone call or email. Outreach assignments are rotated among staff weekly. The approach includes visiting the member's last known address, frequented locations in the community, and local homeless shelters. Additionally, the team contacts natural supports, guardians, advocates, hospitals, the medical examiner's office, probation offices, and jails. Reviewers were provided with a copy of the team's contact guidelines, which outlined	• When 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.

			detailed standards for the frequency and duration of member contact. During the observed program meeting, staff provided updates on planned outreach efforts and attempts, including specific community areas to be searched. Among the member records reviewed, nine showed gaps in engagement ranging from 8 to 25 days between attempts. One record indicated that the team made phone outreach attempts twice a week.	
S4	Intensity of Services	1 - 5 2	Per a review of ten randomly selected member records, during a month period before the fidelity review, the median amount of time the team spends in-person with members per week, is 20.25 minutes. The median duration of phone contact was zero minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. • Ensure staff are trained and supported in appropriate documentation standards to ensure that services delivered are appropriately reflected in medical records in a timely manner. • Ensure services are aligned with members' needs utilizing a client-centered approach. Motivational interviewing techniques are useful when assisting members in identifying goals. Service plans created alongside members, and updated as needed, would identify how the team can support them in reaching their goals.
S5	Frequency of Contact	1 – 5 2	Of the ten records randomly sampled, ACT staff provided a median frequency of 1.25 in-person contacts to members per week.	• Increase the frequency of contact with members, preferably averaging four (4) or more in-person contacts a week. Work

				with staff to identify and resolve barriers to increasing the frequency of contact.
S6	Work with Support System	1 - 5 4	Data provided indicates that 59 members have natural supports. The team tracks these contacts using a weekly spreadsheet kept in a binder. Staff reported weekly contact with approximately 25 members' natural supports occurs mostly by phone or during home visits. Of the ten records reviewed, 50% included documentation of natural support coordination averaging 1.30 natural support contacts per month. Contact frequency ranged from one to six times in the month period reviewed for each of those natural supports. Two members interviewed reported staff have contact with their natural supports 2 – 3 times monthly. Natural support contacts for approximately 19 members were discussed in the program meeting observed. The Peer Support Specialist facilitates a family support group twice a month, averaging 8 – 9 natural supports attending.	• Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four (4) per month for each member with a support system.
S7	Individualized Co-Occurring Disorders Treatment	1 - 5 4	According to the data provided and reviewed with staff, there are 60 members on the roster with co-occurring disorders. Fifty percent of the records reviewed identified members with co-occurring disorders, of those, there were zero records with documented one-to-one individualized co-occurring disorders treatment sessions. Between the two Co-Occurring Disorders Specialists, staff reported six (10%) members	• 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 disorders. • All staff on ACT teams engage members with co-occurring disorders to consider participating in individual treatment sessions. Consider providing training to staff on strategies to engage members in

			receive structured individual counseling related to co-occurring disorders. One specialist meets with five members weekly for one hour, the other specialist meets with one member bi-weekly for one hour.	individualized treatment, as appropriate, based on members' stage of change. • Monitor member engagement and participation in structured individual co-occurring disorders treatment.
S8	Co-Occurring Disorders Treatment Groups	1 - 5 2	Staff interviewed indicate that the team offers two co-occurring disorders treatment groups each week which are facilitated by the Co-Occurring Disorders Specialists. These groups focus on individuals in the earlier stages of recovery. Review of the sign-in sheets from the month prior to the review showed that nine (15%) unique ACT members with co-occurring disorders attended these groups. One member interviewed indicated no longer attending group because after a long history of recovery, the groups did not fit their stage of change.	• Optimally, 50% or more of members with co-occurring disorders attend at least one co-occurring disorders treatment group each month. On ACT teams, all staff engage members with co-occurring disorders to participate in treatment groups, based on their stage of change, with content reflecting stage-wise treatment approaches. • Consider adapting one group for members in earlier stages and one group for members in later stages, allowing staff to adjust interventions to better serve members in different stages of change.
S9	Co-Occurring Disorders Model	1 - 5 3	Staff indicate having familiarity with harm reduction tactics and motivational interviewing techniques to assist members with co-occurring disorders. During the program meeting observed, the stage of change was identified for some members with co-occurring disorders. Staff were less familiar with the principles of a stage-wise treatment approach to interventions. Of the five member records reviewed that were identified by the team with co-occurring disorders, three included treatment plans with interventions, outlining how the team would assist members in progressing toward their recovery goals. Treatment plans are written in	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as *Integrated Co-Occurring Disorders Treatment*, in the principles of a *stage-wise approach* to interventions, and the EBPs of *harm reduction* and *motivational interviewing*. • Ensure treatment plans are written from the member's point of view, recovery focused, and outlines steps the team will take to address substance use while supporting the member in recovery. Support members to identify a *reduction*

			traditional language, rather than detailing supportive steps toward recovery. Additionally, not all treatment plans are written in the member's own voice. Staff reported that, prior to the review, training on co-occurring disorders was conducted at least once a month by agency staff but has not taken place in recent weeks. The Co-Occurring Disorders Specialists are not responsible for providing training on best practices in the co-occurring disorders model. Some staff interviewed recognized that the team would benefit from more comprehensive training.	*of use* goal when a desire for abstinence is expressed. • Support Co-Occurring Specialist staff to provide the team with mentoring and modeling of an integrated co-occurring disorders model. Providing daily support to the team in best practices may improve the level of engagement in services by members.
S10	Role of Consumers on Treatment Team	1 - 5 5	The team has at least two staff with lived or living psychiatric experience and share their story of recovery with members when appropriate. Staff interviewed indicate that the peer perspective provides the team with a deeper understanding of members' needs. Members interviewed were unsure of staff on the team with personal experience of psychiatric care.	
Total Score:		**108**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	2
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
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 Disorders Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	4

6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	4
7. Individualized Co-Occurring Disorders Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.86**	
Highest Possible Score	**5**	