ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: June 13, 2019

To: Mikayla VanArsdel, ACT Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On May 20-21th, 2019, TJ Eggsware and Annette Robertson completed a review of the Terros 23rd Avenue Recovery Center's Assertive Community Treatment (ACT) Team Two. 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 offers services that include: wellness, primary medical, mental health, and substance use care. The agency operates multiple recovery centers in the Central Region of Arizona. The agency operates four ACT teams, two of which are located at the 23rd Avenue Recovery Center. This review focuses on the 23rd Avenue Recovery Center ACT Team Two.

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

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

- Observation of a team meeting on May 21, 2019;
- Individual interview with the ACT Clinical Coordinator (i.e., Team Leader);
- Individual interviews with each of the team's two Substance Abuse Specialists (SASs) and the Peer Support Specialist (PSS);
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of documents and resources, including the Regional Behavioral Health Authority's (RBHA) *ACT Eligibility Screening Tool*, Clinical Coordinator (CC) face-to-face tracking log, substance use group sign-in sheets, substance use treatment resources, the team's *ACT Outreach and Engagement* checklist, and resumes for the SASs and the Employment Specialist (ES).

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item

scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team is staffed with 11 direct service staff, resulting in a member-to-staff ratio of about 10:1. Staffing is of sufficient size to provide necessary coverage to the 98 members served.
- The team is staffed with a Psychiatrist and two Nurses. Interviewees reported that the Psychiatrist and Nurses provide community-based services and are accessible. Members and staff said that the Psychiatrist takes the time to listen and explain.
- The ACT team provides crisis support to members. Members interviewed confirmed that the team is available after business hours by phone and can meet members in the community.
- The team maintained consistency and continuity of care for members, with a low admission rate, and few members transitioned off the team over the year prior to review.

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

- Evaluate employees' motives to maintain employment with the ACT team, as well as causes for turnover. For example, ask current ACT staff about retention efforts to which they might be receptive and how the agency can support them in their roles. The team experienced a high rate of staff turnover, nearly 92%, over the recent two-year period. Optimally, turnover should be less than 20% over a two-year period.
- Evaluate the process in place of taking members to the hospital during business hours rather than engaging them to meet with the Psychiatrist and/or Nurse for assessment. Maintain regular contact with members and their support networks which might result in the identification of issues or concerns that could lead to hospitalization. Educate members and their supports of team availability to support members in their communities or, if necessary, to assist with hospital admissions.
- Work to shift services from the office to the community. ACT teams should perform 80% or more of contacts in the members' communities. Documentation showed nearly half of services occur in the office.
- Increase the intensity of services and frequency of contact with members by ACT staff. Work with staff to identify and resolve barriers to increasing the frequency of contact and intensity of services to members.
- Increase engagement with natural supports as partners in supporting members' recovery goals. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or utilize recovery language when they interact with members. Training staff on informal support engagement strategies may be helpful.
- Provide training to staff on stage-wise treatment, associated interventions, and strategies to engage members in individual and/or group treatment. Some agencies have purchased and disseminated to ACT teams treatment manuals and resources to ensure staff draw from the same information. Both SASs should receive supervision so they can cross-train other specialists in substance use treatment.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 98 members with 10 staff that provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of about 10:1.	
H2	Team Approach	1 – 5 4	Staff said they do not have caseloads, but some are assigned to activities for subgroups of members. These include the PSS who typically handles criminal justice matters, including visiting members who are incarcerated. Members with a substance use diagnosis are divided between the two SASs. Another staff coordinates with special assistance contacts (e.g., guardians, advocates). One staff estimated that about 80% of members likely receive face-to-face contact with more than one staff over a two-week timeframe. Based on sample records reviewed, 70% of members received face-to-face contact with more than one staff over a two week period. Members said that they have contact with multiple staff, ranging from three to five weekly.	• Review the current contact strategy with the team to ensure implementation as intended. Track whether staff attempts visits. Confirm that attempts and successful contacts are documented. Ideally, at least 90% of members have contact with more than one staff over a two week period. Consider monitoring the diversity of staff contact that occurs with members during the team meeting.
H3	Program Meeting	1 – 5 5	Staff said that the program meeting is scheduled for one hour four days a week. Staff attends meetings on the weekdays they are scheduled to work. The Psychiatrist and Nurses work four ten-hour days. During the meeting observed, the team discussed all members. Near the top of the hour the pace of the meeting sped up significantly. As a result, notably less time was spent discussing about 24 of the members whose last names fall near the end of the alphabet.	• If not occurring, reverse the order members are discussed from meeting to meeting so that those whose names fall near the end of the alphabet receive equal discussion time.
H4	Practicing ACT Leader	1 – 5 2	The CC estimated spending about 50% of her time providing direct services to members. Few examples of direct services by the CC were found in ten member records. Most contacts were brief	• Identify and address barriers to the ACT CC providing at least 50% of the time in direct services. Optimally, CC's delivery of direct services to members should account for at

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			check-ins with members when they attended appointments with other team staff. Based on review of the CC's productivity report over a month, direct services were provided to members about 5% of the time. It appears that the CC provides occasional backup services.	least 50% of the time and be documented in the members' records. If new staff join the team, supervision might include the CC mentoring them as they deliver services.
H5	Continuity of Staffing	1 – 5 1	The team experienced a high rate of staff turnover. Data showed that 22 staff left the team during the recent two-year timeframe, resulting in a nearly 92% turnover rate. Turnover was highest for the Housing Specialist and Nurse positions, but multiple staff also filled the roles of CC, ES and Peer Support Specialist (PSS). Interviewees reported some employees who left the team were hired in similar positions at other agencies. One staff left and later rejoined the team; he was not included in the turnover rate.	• When possible, examine employees' motives for resignation, and attempt to identify other causes for employee turnover. Optimally, turnover should be less than 20% over a two-year period. Consistent staffing is a key ingredient in successful ACT teams. • In an effort to support retention, ensure staff receives training and supervision for their specialty.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 92% of staff capacity over the past year. There was a total of 12 months with position vacancies.	• Fill vacant positions with qualified staff as soon as possible.
H7	Psychiatrist on Team	1 – 5 5	Staff said that the full-time Psychiatrist is an active team member and is available to staff to discuss issues as they arise. The Psychiatrist works four ten hour days attending meetings on those days unless an urgent member issue arises. Members and staff said that the Psychiatrist takes time to listen and explain things to them. Staff said that the Psychiatrist typically provides community-based services to members one day weekly; visiting members while inpatient, in their homes, and in the community.	
H8	Nurse on Team	1 – 5 5	There are two full-time Nurses assigned to the team. Staff reported that the Nurses are accessible and responsive. Neither Nurse has administrative responsibilities and rarely provides services to	

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			members from other teams at the clinic. Both work four ten-hour days and attend the team meeting on the weekdays they are scheduled to work. One Nurse is scheduled to work on Saturday. Examples of the Nurses providing services to members in the community were not found in records reviewed. However, some members said that Nurses have visited their home.	
H9	Substance Abuse Specialist on Team	1 – 5 5	Two SASs work on the team, one of whom is titled Substance Abuse Counselor (SAC). The SAC reported receiving weekly supervision. Based on interviews and resumes, each SAS has more than one year experience providing substance use treatment. The SAC joined the team February 2017 and is a Licensed Master of Social Work. The second SAS joined the team July 2018. Prior to that, he worked as a Lead Substance Abuse Clinician for about two years.	• Provide both SASs with supervision and training in co-occurring treatment best practices so they are each able to cross train other staff in appropriate interventions based on members' stages of treatment.
H10	Vocational Specialist on Team	1 – 5 3	The team employs one Employment Specialist (ES). The second Vocational Specialist (VS) equivalent role, the Rehabilitation Specialist (RS), is vacant. The ES joined the team in October 2018 and prior to that worked as a Vocational Rehabilitation Counselor for nearly two years and as a Job Developer for about four years.	• Seek to fill the second VS position with someone that has experience helping members to obtain competitive positions in integrated work settings. Ideally this staff person should have experience with job development, supporting individualized job searches, and follow-along support.
H11	Program Size	1 – 5 5	At time of review, with 11 direct service staff, the team is of sufficient size to provide coverage.	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported referrals originate from other teams at the clinic or through the RBHA. The CC usually meets with the potential new member to complete the RBHA's screening tool and then meets with the Psychiatrist to discuss the results. The CC and Psychiatrist make the final decision if members join the team, with no external	

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			mandates to accept admissions. They may occasionally include the site Clinical Director.	
O2	Intake Rate	1 – 5 5	Monthly admissions to the team over the prior six months peaked at three members during the month of February 2019. There were zero admissions November 2018 and April 2019, one each month during December 2018 and January 2019, and two admissions March 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric services, individual and group treatment for substance use, employment support, and psychotherapy/counseling. During the team meeting, the team discussed the ES providing supportive employment services. Staff reported that no members are with a brokered provider for supportive employment services. Members interviewed said that there are specialists on the team who can assist with housing, employment, and other services. Psychotherapy/counseling is available through the SAC. Staff said no members receive counseling from other providers. On occasion members may be referred to a brokered provider. For example, if a member prefers to receive treatment from a female counselor. The team provides in-home services and assists members to explore housing options. Examples were documented of the Housing Specialist discussing housing with members. This included discussing lease terms and potential consequences of infractions, such as guests staying with tenants for an extended period. The HS assisted a member to resolve an issue of a person who was in a	• Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff support. Optimally, no more than 10% of ACT members reside in settings where other social service staff provides support. • For members in staffed settings, the team should discuss when staff from those settings mandate activities or treatment for members. Evaluate if the mandated activities are appropriate and align with best practices. Advocate with, and on behalf of, members.

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			member's residence against their preference. However, based on interviewee reports, more than 10% of members live in staffed residences. Some staff cited examples of members in staffed residences as a requirement through the legal system. One staff estimated a low of about 5% are in staffed residences, but another estimated about 12% and one reported 13% of members are in staffed residences. Staff accounts on the types of staffed settings varied. It was not clear if there was shared awareness of member statuses. Settings range from formal residential treatment settings to group living where house staff may require members to take part in certain activities (e.g., detoxification, groups or chores) or may hold and dispense medications.	
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the ACT team is available to provide crisis services, including responding to members in the community. Some staff work weekend shifts, including one Nurse. Members interviewed confirmed that the team is available after business hours and can meet them in the community. Staff provides to members a contact list that includes the on-call and staff phone numbers with brief position descriptions. The document provided for review did not include the new ILS staff.	• In addition to updating the staff contact list as new staff join the team, consider further enhancing the document by adding staff hours of availability.
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff said that if a member requests inpatient services, staff will transport them to the hospital. It does not appear that there is a process in place to engage members to meet with a Psychiatrist and/or Nurse before inpatient treatment. Staff said that some members seek inpatient treatment without informing the team and the team may not receive immediate notification of an admission.	• Evaluate the process in place when members request inpatient admission. Ideally, teams prioritize supporting members in the community by increasing ACT services, engaging with informal supports and exploring community resources to divert hospital admissions. As a step, during regular business hours,

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			Based on information provided, the ACT team was directly involved in 60% of the ten most recent hospital admissions. Staff said it was unknown what led to two member admissions; one of those members was out of contact with the team. The two other members were transported to inpatient settings by police. In a record reviewed, a member was at a setting where staff attempted to visit. Staff learned that the member was moved to an inpatient facility. There was no team visit to the member at the inpatient setting for five days.	evaluate whether members can meet with the Psychiatrist and/or a Nurse before inpatient admission. • Maintain regular contact with all members and their support network. This may result in the identification of issues or concerns that could lead to hospitalization. Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said that the ACT team was directly involved in each of the ten most recent hospital discharges. Staff said that they visit with members within 24 hours of learning of a member's admission and every 72 hours thereafter. Staff usually visit members on Monday, Wednesday and Friday, but visits may occur over the weekend. Staff said that they coordinate with the inpatient treatment team, establish a discharge plan and that the Psychiatrist conducts doctor-to-doctor consultations with the inpatient provider. The team typically meets members at discharge to provide transportation to their discharge setting. Though, in some situations staff may not inform each other where members are brought after discharge. In a record reviewed staff documented that a member was discharged and transported to the home of a friend but it was not clear if staff relayed the location to the team. The member missed an appointment the next day. Staff conducted outreach to the person's last known address. After members discharge, staff said that they have face-to-face contact for five days.	• Evaluate the process the team uses to share information with each other. Ensure that staff communicate with each other when member statuses change.
O7	Time-unlimited	1 – 5	The ACT team did not report any graduations from	

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	Services	5	the team over the past year. One member requested step-down to a less intensive service level. Staff identified one member as a potential graduation in the next 12 months.	
S1	Community-based Services	1 – 5 3	Staff reported they spend the majority (75-90%) of their time in the community. In ten member records reviewed, a median of 51% of services occurred in the community, an increase from the prior year review. It was not always clear if community-based visits were planned ahead with members to ensure they would be at the location as there were many attempts made when the member was not home to receive staff. Certain members reported they met with staff more often at the office, one reported a mix of office and community contacts, and one said staff visits them daily for medication service.	• Work to shift the locus of service from the office to the community. ACT teams should perform 80% or more of contacts in the members' communities where staff can directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting. Engage members in the community at a similar level as what was reported by staff interviewed. • Ensure staff document in records all attempted and completed member contacts.
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the prior year, the team retained about 98% of members. A member transferred to another provider after a period when they were out of contact with the team. Staff learned that another member was assigned to a less intensive team for services. One member left the geographic area without referral or notifying the team. Staff confirmed services were arranged for one member who moved from the area. Interviewees confirmed that if members do not want ACT services, staff tries to re-engage members to problem solve solutions. One member reported an experience when they wanted to transition from ACT. The Psychiatrist met with the member to discuss the issue.	
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff said when members are not in contact with the team they conduct outreach for eight weeks and then members transition to *Navigator* status	• Monitor contacts with members. Ensure community-based outreach occurs and is documented. It may be useful to assign one

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			but none transitioned off the team to that level in the last year. Staff said that if they fail to perform outreach for a week, they begin the eight week process again. The Reviewers were provided a copy of the checklist the team follows titled *ACT Outreach and Engagement*. The checklist has space to track up to four outreach efforts per week. It prompts staff to conduct community-based outreach at least twice weekly for five of the eight weeks, in addition to office-based efforts (e.g., telephonic, letter). During the program meeting, staff discussed outreach to members. However, in ten member records reviewed, there were gaps in documented outreach or contact of a week or more, for three members, over a month timeframe.	staff to review documentation in member records during the team meeting to confirm recent contacts occurred so that the team can proactively assign staff to outreach in the event of lapses. • Consider enhancing the eight week checklist to prompt for more community-based outreach. As a first step, prompt for at least two community-based outreach attempts per week, in addition to the office-based or other telephonic activities.
S4	Intensity of Services	1 – 5 2	Based on review of ten records, the median intensity of face-to-face service time per member was around 39 minutes weekly; one of the members received more than 120 minutes average of weekly service time. Some staff documented more detailed contact notes than other staff and some may use a template approach to documentation. An example was found of a staff documenting contact with a member on two different dates, but notes had the same content.	• The ACT team should provide members an average of two hours of face-to-face contact weekly. Work with staff to identify and resolve barriers to increasing the average intensity of services to members. • Monitor face-to-face contacts with all members weekly and ensure they are accurately documented allowing for individualization of services delivered.
S5	Frequency of Contact	1 – 5 2	Staff said there is a system in place that should result in members receiving at least three weekly face-to-face contacts. The team uses a rotation strategy where members who reside in similar areas of the service area are clustered. Over the course of a specialist's workweek, they are assigned three clusters of members for contact, one grouping per day, in addition to a day for in-	• Increase the frequency of contact with members by ACT staff, preferably averaging four or more face-to-face contacts a week per member. Work with staff to identify and resolve barriers to increasing the frequency of contact with members. Evaluate and consider modifying the current rotation strategy. Ensure contacts

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			office coverage (i.e., Blue Dot). A median weekly face-to-face contact of just over 1.6 was found in ten records, including five members who received an average of one or fewer contacts weekly over a month timeframe.	and attempts are documented.
S6	Work with Support System	1 – 5 1	Staff estimates of members with informal supports were a low of 26% and a high of 54% or 60%. One staff estimated that the team is in contact with informal supports, on average, about monthly. Another staff estimated contact occurs at least twice a month for about 26% of members and one said the team has weekly contact with informal supports for about 27% of members. Two members interviewed confirmed that staff made contact with their informal supports. During the program meeting, staff discussed recent contact with informal supports, or planned contact, for 14 members. In ten records, two brief contacts with informal supports were documented. In both, the contacts occurred when staff tried to visit members who were not home. One member was at the clinic when staff attempted to visit.	• The team may benefit from further training on strategies to assist members in building and engaging natural supports. Discuss with members the benefits of involving their supports in their treatment. • Educate informal supports about how they can support members' recovery. For example, assist them to identify community-based activities they can engage in with members. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or model use of recovery language. • Monitor accuracy of documentation of contacts with informal/natural supports in the member records.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Based on interviews and observation of the team meeting it appears individualized substance use treatment is available through SASs on the team. However, it does not appear the average session is 24 minutes or more per applicable member. The number of members with a co-occurring diagnosis was requested. Ultimately, staff identified 77 members with a substance use diagnosis. Each SAS is assigned approximately half of those members as the primary staff to provide substance use treatment. One SAS reported meeting with 15-17 members weekly for individual treatment.	• Staff should offer individual treatment to members with a co-occurring diagnosis. Explore training on strategies to engage members in substance use treatment. Individualized treatment may be more appropriate for members in earlier stages of treatment. • Continue all efforts to increase the time spent with members in individual sessions to 24 minutes or more, per applicable member, and documenting it in the clinical record. • Ensure that both SASs receive the

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			During the team meeting, staff referenced individual treatment. However, in ten records documentation did not show individual treatment was regularly offered or provided. The records were representative of the number of members on the team with a substance use diagnosis; eight of the ten members have a substance use diagnosis. There were two examples of one of the team specialists encouraging members to participate in individual treatment, an example of an SAS discussing triggers with a member, relapse prevention plan and motivators for recovery.	necessary training, mentoring, and ongoing guidance to provide structured, individual substance use counseling to members identified with a co-occurring diagnosis. Ensure other specialists, in addition to the SASs, inform members of individual treatment available with the SASs. • Ensure individual treatment is regularly offered.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Each SAS offers a treatment group for members in different stages of recovery, and it was reported that the PSS was re-starting a group for members determined to be in the pre-contemplation stage. There were examples in member records of staff inviting members to attend group treatment. Based on sign-in sheets, over a month timeframe, about 16-17% of members with a substance use diagnosis attended group at least once. Some names were not listed on the roster of individuals with a substance use diagnosis or the full member roster. It is not clear if those members are served by other teams at the clinic and their participation was not factored for this item.	• Engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring group. • Ensure that the SASs receive the necessary training, mentoring, and ongoing guidance to provide structured group treatment to members with substance use diagnosis. The same training and guidance should be provided to the PSS, or any other staff who facilitates group substance use treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Staff gave examples of recent harm reduction efforts and reported to receiving training in Integrated Dual Disorder Treatment (IDDT). Staff provided the IDDT treatment resource they utilize, available on the internet. Sign-in sheets of recent education sessions to the team in substance use treatment facilitated by the SAC were provided.	• Provide training to all staff on an integrated approach to substance use treatment, including a stage-wise approach (i.e., engagement, persuasion, active treatment, and relapse prevention). Having a common treatment approach should benefit the members served and help staff to align their activities appropriately.

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			Based on interviews, it does not appear all staff are familiar with stage-wise treatment. Staff are familiar with stages of change and discussed members' stages during the meeting observed. The team does not directly refer to Alcoholics Anonymous (AA) or similar groups, but some members reside in settings where they may be mandated to participate. Similarly, staff at certain settings may require members to participate in detoxification, at times asking ACT staff to transport members to those settings. Staff reported that they will arrange for detoxification if members request it. Some staff may use a more confrontational approach when addressing substance use with members. Due to the brevity of certain progress notes, the extent certain staff utilized Motivational Interviewing or drew from IDDT was unclear. Certain treatment plans referenced substance use but did not include specific services. The format of some plans did not appear to capture all information. On some plans, the needs listed were incomplete, ending mid-sentence, which appeared to be a feature of the service plan layout. In some cases a member signed plan was located, but a more recent unsigned plan, with adjustments, was in the electronic record.	• Review with staff to ensure accurate documentation of services on treatment plans. For example, referencing substance use treatment by an SAS, staff activities based on a member's stage of treatment, and individualized information. • Discuss with staff under what circumstances withdrawal management (i.e., detoxification) may be medically indicated. Some staff may be better equipped to support members and to advocate for them to receive appropriate intervention based on their status.
S10	Role of Consumers on Treatment Team	1 – 5 5	Interviewees confirmed there is an employee on the team with direct lived experience of mental health recovery. Members reported certain staff disclose aspects of their lived experience.	
Total Score:		**3.79**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	1
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	5
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	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	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	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.79**	
Highest Possible Score	**5**	