ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 3, 2020

To: Breck Vanderhoof, ACT Clinical Coordinator
Tom McKelvey, CEO

From: T.J. Eggsware, BSW, MA, LAC
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AHCCCS Fidelity Reviewers

Method

On December 2-3, 2019, T.J. Eggsware and Annette Robertson completed a review of the Lifewell Behavioral Wellness Royal Palms 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.

Lifewell Behavioral Wellness offers outpatient, supported employment, housing and residential services. The agency operates two ACT teams, and this review focuses on the Royal Palms team. Management of the Royal Palms clinic transitioned from another provider to Lifewell Behavioral Wellness in May 2018.

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

During the site visit, reviewers participated in the following:

- Observation of a team meeting on December 2, 2019;
- Individual interviews with the Clinical Coordinator (i.e., Team Leader), each Substance Abuse Specialist (SAS), and the Employment Specialist (ES);
- Group interview with three members who receive services from the team;
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of documents, including: Clinical Coordinator (CC) face-to-face service tracking report, resumes and training records for the SASs and vocational staff, substance use treatment resources, sample member calendars, the team *Outreach Log* and ACT brochure, and, the Regional Behavioral Health Authority (RBHA) *ACT Admission Criteria*, and *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual*.

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

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The ACT team meets five days a week to discuss members. During the team meeting observed, multiple staff contributed to discussions. Staff reported that the Psychiatrist, Nurses and other specialists attend the team meeting on the weekdays they are scheduled to work.
- As of the date of review, the team is staffed with 12 staff, sufficient to provide the necessary coverage to the 98 members served. The member-to-staff ratio is about 9:1. The team is staffed with a Psychiatrist and two Nurses.
- The ACT team provides crisis support to members, are available after business hours by phone, can meet members in the community, and some staff work weekend hours. Members said staff provided them with a document or card with the on-call number.
- The team maintained consistency and continuity of care for members with a low admission and drop-out rate for the period reviewed.

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

- Identify administrative tasks currently performed by the CC that may be transitioned to other administrative or support staff. Optimally, the CC's delivery of direct services to members should account for at least 50% of the time.
- Attempt to identify factors that contributed to staff turnover, or, conversely, supported retention. The members experienced considerable staff turnover in the prior two years. Based on data provided, 16 staff left the team, a turnover rate of 67%. Over the prior year, nine staff left the team.
- Engage or enhance support to members that receive a lower intensity and frequency of service. The ACT team should provide members an average of two hours of face-to-face service time and an average of four or more contacts weekly. Optimally, the majority of services are delivered to members in their communities. Monitor documented outreach and contacts with members and evaluate the team's approach to building rapport with disengaged members. Ideally, the Psychiatrist and Nurses also provide community-based services.
- Evaluate what prevented staff from directly supporting members during hospital admissions. Maintain regular contact with members and their support networks, which might result in the identification of issues or concerns that could lead to hospitalization.
- Increase engagement with natural supports as partners in supporting members' recovery goals. Training staff on strategies for engaging informal support may be helpful. Staff may then be able to advise informal supports on how they can reinforce healthy recovery behaviors or use recovery language when they interact with members.
- Provide training to staff on stage-wise treatment, associated interventions, and strategies to engage members in individual and/or group treatment. Both SASs should receive supervision so they can cross-train other specialists in substance use treatment. Evaluate the content of the substance use treatment groups and individual treatment to ensure the use of a co-occurring treatment approach.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 98 members with 11 staff that provide direct services, excluding the Psychiatrist, resulting in a member to staff ratio of 9:1.	
H2	Team Approach	1 – 5 5	Staff said that nearly all members receive face-to-face contact with more than one staff over a two-week time frame. Based on sample records, 90% of members received face-to-face contact with more than one staff over a two-week period.	
H3	Program Meeting	1 – 5 5	Staff said that all members are discussed during the team meeting, held Monday - Friday. Specialists attend on the weekdays they are scheduled to work. The Psychiatrist attends full meetings four days weekly and was off on the day of the meeting observed. All members were discussed during the meeting observed. Staff reported on their contacts over the weekend, the previous week, and planned contact for members.	
H4	Practicing ACT Leader	1 – 5 2	The CC reported providing direct services 30%-40% of the time. In ten records there were few examples of CC services over a recent month; one contact with a member at the clinic and two emails to a guardian. Based on review of the CC's productivity report, the CC provided direct services 3% of the time over a recent month time frame.	• Optimally, the CC's delivery of direct services to members should account for at least 50% of the time. • Identify administrative tasks currently performed by the CC that may be transitioned to other administrative or support staff.
H5	Continuity of Staffing	1 – 5 2	The members experienced staff turnover in the prior two years. Based on data provided, 16 staff left the team since December 2017, a turnover rate of 67%. Over the prior year, nine staff left the team. The highest turnover occurred in the Nurse position. Multiple staff also filled the roles of Psychiatrist, Peer Support Specialist, ES, and SAS.	• Ideally, turnover should be no greater than 20% over a two-year period. Attempt to identify factors that contributed to staff turnover or supported retention. • Support specialists in their role. Staff find more satisfaction when able to use their skills in their position.
H6	Staff Capacity	1 – 5	The team operated at approximately 91% of staff capacity over the prior year. There was a total of	• Recruit qualified candidates to fill vacant positions when staff leave the team.

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		4	13 months with position vacancies. The Housing specialist (HS), Peer Support Specialist (PSS), and ES positions were vacant for multiple months.	
H7	Psychiatrist on Team	1 – 5 5	The Psychiatrist joined the team November 2019, less than a week after the previous Psychiatrist left the team. Staff said that the current Psychiatrist is shadowing another agency Psychiatrist who also provides coverage to the team. Members reported that they usually meet with the Psychiatrist once monthly. Staff said that the prior Psychiatrist conducted community-based services weekly on Wednesdays, usually for a full day, and the plan is for the new Psychiatrist to follow that schedule. No examples of Psychiatrist community-based services were found in the reviewed member records. Two members did report that a Psychiatrist visited them at their home.	
H8	Nurse on Team	1 – 5 5	The ACT team has two full-time Nurses. Both Nurses work four, ten-hour days. Staff said that before the second Nurse joined the team during mid-November 2019, the sole Nurse provided most services to members at the clinic. Staff said when the team was staffed with two Nurses; they provided community-based services. The reviewers found one example of a community-based service provided by a Nurse in the sample records. A member reported a Nurse visited them in their home twice. Staff said that both Nurses share equal responsibility for medication education, preparation, and injections and other nursing care. Staff said that the Nurses attend team meetings on the weekdays they work, and are accessible by phone, email, and text, including after hours and weekends. Staff said that the Nurses do not provide services to members served	

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			by other teams at the clinic, and neither have other duties outside of the team.	
H9	Substance Abuse Specialist on Team	1 – 5 4	The team is staffed with two SASs. One SAS is a Licensed Independent Substance Abuse Counselor (LISAC). The second SAS worked with the team in another specialist role before transitioning to the SAS position in August 2019. The second SAS's resume shows experience on ACT teams, assisting members with housing, employment, and crisis services. It does not appear that providing substance use treatment was a primary aspect of the second SAS's prior positions. The second SAS's training record showed trainings in integrated treatment for co-occurring disorders, Integrated Dual Disorder Treatment (IDDT), motivational interviewing trainings, and American Society of Addiction Medicine (ASAM).	• Provide both SASs with training in co-occurring treatment best practices. SASs may then be better equipped to cross-train other staff on the team in the adopted co-occurring model and appropriate interventions based on members' stages of treatment. Optimally, ACT teams are staffed with two SASs, each with a year or more of training/experience providing substance use treatment.
H10	Vocational Specialist on Team	1 – 5 5	The team employs a Rehabilitation Specialist (RS) who joined the team September 2014 and an ES who joined the team September 2019. In addition to time in their current positions, the RS and ES completed trainings in vocational services. The ES previously worked on another ACT team as a RS. Staff said that vocational staff attends in-person RBHA employment trainings.	• Ensure both vocational staff receive ongoing training in helping members find and retain competitive employment in integrated settings.
H11	Program Size	1 – 5 5	At the time of review, with 12 staff, the team is of adequate size.	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported that they actively recruit when the member census is lower than 100 members. Staff said they recruit for referrals, for example, internally from other teams at the clinic and during visits to members who are inpatient when they interact with social workers at those facilities. Staff said that referrals also stream through the	

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			RBHA or are directly referred from other providers. The ACT team uses the RBHA developed *ACT Admission Criteria* to screen potential admissions; a copy was given to the reviewers. The CC or other staff meets with potential members to complete the screening. The screening information is reviewed with the team. The Psychiatrist determines if members join the team. Staff reported no administrative pressure to admit members to ACT.	
O2	Intake Rate	1 – 5 5	Over the prior six months, the peak member admission rate was four during October 2019. There were three admissions each month during June, July, August and November 2019, and, two admissions September 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 5	The team provides case management, psychiatric services, substance use treatment, and most housing and employment support service. Members reported that specialist staff on the team help with housing and employment services. Based on staff interviews and observation of the team meeting, the vocational staff engages members to explore employment options or opportunities to increase skills. One staff said the team provides employment or rehabilitation related support to about half of all members, including about 15 members who work full or part-time. One staff estimated about 70%-80% receive employment or rehabilitation related support and 10% are employed. At the time of review, staff reported at least one or two members participate in Work Adjustment Training (WAT) through a brokered provider.	• Educate staff on the benefits of ACT staff engaging and directly supporting members with rehabilitation and competitive employment goals rather than engaging them to participate in temporary WAT activities or employment services with brokered providers. • Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff support. • Determine if tasks (e.g., medication observation) assigned to the staff that provides counseling can be shifted to other staff so they can remain available to offer counseling. Counseling/psychotherapy should be available on ACT teams. • Continue to educate staff from other agencies or systems (e.g., criminal justice system representatives) of ACT services,

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			Staff said that members transition off the ACT team within 30 days of placement in residential treatment. Based on staff interviews, less than 5% of ACT members are in staffed locations. Staff reported no members are in residential treatment settings. A staff reported one member receives one-to-one services in their residence with an outside provider. Staff said there is one member in a substance use treatment program as mandated through the criminal justice system. Staff reported no members are currently in a half-way-house or similar setting. Staff reported two members, who receive services through the Division of Developmental Disabilities, reside in staffed residences. Counseling is available through an ACT staff, but one staff said that there may be a reduction in the number of members who receive individual counseling through ACT staff due to a realigning of responsibilities. Some staff were uncertain of the number of members who receive individual counseling through ACT staff. Other staff said six to ten members receive counseling through the team. Two members receive specialty counseling from brokered providers.	such as substance use treatment.
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the ACT team is available to provide crisis services 24 hours a day, seven days a week. The CC serves as the back-up to the on-call and is available to on-call staff to coordinate with the Psychiatrist and/or Nurse. Members interviewed confirmed that staff is available after hours. Members said staff provided them with a document or card with the on-call number. Staff provided, for review, a brochure that is given to members with a brief description of ACT. The	

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			brochure identifies the team on-call number. The brochure lists the CC, Program Assistant and specialists' names, positions, and contact numbers.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff said that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide services. Staff are available to coordinate admissions. Staff said that they meet with members and a doctor-to-doctor consultation is attempted within 24 hours of being informed of an admission. Staff then meet members weekly on Monday, Wednesday and Friday. Based on information provided, the ACT team was directly involved in five of the ten most recent hospital admissions. Three members self-admitted and two were brought to the setting by police. The team was not informed until the third day after the admission date for one of those members.	• Evaluate what contributed to members not seeking team support prior to self-admissions or situations when the team was not involved in the admission. • Educate members and their support systems about team availability to support members in their communities or to assist with hospital admissions. • Maintain regular contact with all members and their support networks. This may result in identification of issues or concerns that could lead to hospitalization, allowing the team to offer additional supports, which may reduce the need for hospitalization.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff said that the ACT team was directly involved in each of the ten most recent hospital discharges. Staff said that they coordinate with inpatient staff. In a record reviewed, for a member that was inpatient, staff did not meet with the member every 72 hours. Staff did not document visits with the member over periods of seven, five and four days. Staff from the team usually meets members at discharge to provide transportation. Staff said that when members are discharged, they have follow-up appointments with the Psychiatrist within 72 hours and the Nurse within 24 hours. Staff reported that they attempt face-to-face contact with members for five consecutive days after a	• Track member discharge services, including visits to members who are inpatient, in order to prevent lapses. Track follow-up contact with members in order to follow agency and/or RBHA guidelines.

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			hospital discharge. At least one of those visits is attempted at the member's home. In a record reviewed, for a member who discharged from an inpatient setting, staff documented contact for three of the five days identified for follow up.	
O7	Time-unlimited Services	1 – 5 5	Staff reported that over the prior year, three members graduated from the team and projected at least two graduates in the upcoming year. Staff reported that the process is determined by the member's status and if they achieved their goals.	
S1	Community-based Services	1 – 5 3	Staff reported delivering 80%-85% of direct member services in the community. In ten member records, a median of 53% of services occurred in the community. Multiple staff contacts were documented for some members when they visited the office. Members said that staff meets them equally in the community and office. One member confirmed that staff visits them if they are inpatient or incarcerated.	• Increase the delivery of services to members in their communities. Evaluate what clinic-based activities can transition to occur in members' communities. Optimally, 80% or more of services occur in members' communities.
S2	No Drop-out Policy	1 – 5 5	Based on data for the prior year, no members closed in the 12 months prior to the review due to lack of contact. Three members left the service area without referral: two did not notify the team prior to their moves; one declined assistance. One member elected to transition to another provider and one member transitioned to another system of care. Staff said that no other members closed from ACT due to refusing services, not being located, or the team determining they could not be served. A *Navigator* system is in place, but no members transitioned off the team to that status in the prior 12 months. Staff reported six members transitioned off the team due to placement in 24-hour residential treatment.	
S3	Assertive	1 – 5	Staff said that when members are not in contact	• Monitor documented outreach and

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	Engagement Mechanisms	4	with the team, such as if they have not met with the Psychiatrist for 30 days, four weekly outreach attempts occur for eight weeks. Staff said that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide their outreach. Staff provided the reviewers with a copy of the *Outreach Log*, which indicates that outreach occurs for seven weeks. On the eighth week, the member is discussed with the CC for closure. In records, over a month time frame, there were gaps in documented contact. For one member, six days lapsed between contacts. During that time the member missed a Psychiatrist appointment. It was not clear if the missed appointment was discussed when staff met with the member. A member was incarcerated, and staff documented two visits and an attempted visit over a month period. Staff documented two outreach efforts for one member over a week period, and after an interaction, no contact occurred for more than a week. During that time, the member was arrested. Following a court appearance, attended by staff, when the member was released staff made no contact for more than a week. For another member, staff documented one outreach attempt over a seven-day period. Some sample member calendars provided showed lapses or limited contact with members by staff.	contacts with members. It may be useful to assign one staff to spot-check documentation in member records during the team meeting to confirm recent contacts or outreach efforts are documented. This may enable the team to proactively assign staff to outreach or contact in the event of lapses. • Consider identifying factors that initiate immediate member follow up from the team (e.g., missed psychiatric appointments).
S4	Intensity of Services	1 – 5 2	The median weekly intensity of face-to-face service time spent per member was 49 minutes based on ten member records. Only one member received an average of more than 120 minutes weekly. The average weekly service per member ranged from under 8 to 213 minutes. Most members received an average of between 28 to 60	• Evaluate how the team can engage or enhance support to members who receive a lower intensity of service. The ACT team should provide members an average of two hours of face-to-face contact weekly. • Ensure staff are trained on appropriate

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			minutes of service time weekly. Some members participate in clinic-based groups with staff who are not on the ACT team. Member participation in those groups was not factored.	documentation standards so services can be accurately reflected in the members' medical records.
S5	Frequency of Contact	1 – 5 3	Members said they met with two to three staff over the prior seven-day period. In records, there was a median of just over two weekly face-to-face contacts for ten members. Documented contacts with members in ten records range from less than one weekly to 12. Three members received an average of four or more contacts weekly. Staff contacts with two members exceeded the other eight members combined.	• Increase the frequency of contact with members, preferably averaging four or more face-to-face contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. Seek to balance services delivered to more frequently visited members with members who staff meet with less often.
S6	Work with Support System	1 – 5 3	Members interviewed who have supports said that staff keeps in contact with their natural supports. Staff said that the team attempts weekly contact with informal supports. Staff reported varying estimates of members with natural supports systems, ranging from 25% - 97%. Based on records, the ACT team documented less frequent contact with informal supports for some members than interviewees reported. In ten records, over the course of a month, staff documented a total of 12 contacts with informal supports, six contacts with informal support for one member, two contacts with supports of one member, and one contact each for four members. During the program meeting observed, staff discussed recent or planned contact with informal supports, for 17 members.	• The team may benefit from further training on the benefits of informal supports and strategies to assist members in building and engaging natural supports. Discuss with members the benefits of involving their supports in their treatment. • Educate informal supports about how they can support members' recovery. For example, assist them to identify community-based activities they can engage in with members. Staff may be able to draw from their training to give informal supports tips on how they can reinforce healthy recovery behaviors or model use of recovery language.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported that the team serves 62 members with co-occurring diagnoses. Individual substance use treatment engagement was discussed during the team meeting for a small number of the applicable members. Staff interviewed reported	• Consider training the team on strategies to engage members in substance use treatment. • Work to increase the time spent in individual sessions so that the average time

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			that 15-20 members received individual sessions in a recent month time period. One interviewee said 10-12 members receive one or more sessions weekly, each contact lasting 30 minutes or more. Data showed seven of the ten members in the record sample having a substance use diagnosis Staff offered counseling, but few examples of individual treatment were found in records. No members received individual treatment at the frequency reported by staff.	is 24 minutes or more across the group of members with co-occurring diagnoses. • Evaluate if SASs sharing in other duties, such as medication observation, limits their ability to engage or provide individual substance use treatment. Consider shifting those duties to other staff, if indicated.
S8	Co-occurring Disorder Treatment Groups	1 – 5 1	Staff said that two co-occurring groups are available, open to members in varied stages of change. One staff interviewed reported about 16%-24% of members with a substance use diagnosis attended group treatment over a recent month period and another staff said one to two members attended. Staff reported that for some scheduled groups, one member attended. Due to low attendance, sign-in sheets were not available to reviewers. Over a month time frame, documentation in sample records showed no applicable members participated in group substance use treatment. Documentation showed staff inviting members to substance use treatment groups with the SASs, groups with other specialists, and groups facilitated by other non-ACT staff at the clinic.	• Staff would benefit from training on strategies to engage members in group substance use treatment • Engage members to participate in group substance use treatment, as appropriate, based on their stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring group. • Consider adapting one group for members in earlier stages and one group for members in later stages. It should allow staff to adjust their interventions to better serve members in different stages of treatment. • Ensure the SASs use stage-wise interventions.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Staff said that the team does not refer to Alcoholics Anonymous (AA) or similar groups. One staff said that the team does not refer members to detoxification. Another staff said that the team occasionally refers members for medical withdrawal management and gave examples of substances likely to require that support. Staff gave examples of harm reduction, including	• Review with staff how IDDT and stages of change are distinguished. There are resources online that can introduce staff to the complimentary aspects of the two models: IDDT; and, stages of change. • Train all staff in a stage-wise approach to treatment, including how specific interventions are directed to members

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			supporting members to reduce or eliminate more harmful substances before focusing on less harmful substances. In a record there was an example of staff engaging a member to decrease the frequency of use of a substance over a day, or to not use the substance for one day. Staff is familiar with stages of change and reported the stage of change for some members during the meeting observed. Staff did not appear to be as familiar with *stage-wise* treatment. However, training records showed that staff participated in IDDT training modules and staff said that the team uses IDDT. Staff said that the team meets for trainings in IDDT. The staff who conducts some of those trainings reported that their experience was from online trainings. Staff provided other examples of treatment manuals and resources they utilize. Although there may be beneficial elements of each resource, more comprehensive approaches are available for individuals with co-occurring diagnoses. One staff uses the *Counselor's Treatment Manual Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders*. As the title indicates, the approach is targeted at individuals with stimulant use challenges. The approach establishes the need for total abstinence. The manual includes an example agreement for participants that requires abstinence. The manual has a reference to referring out members with co-occurring substance use and mental health issues. One staff provided for review an IDDT poster printout. One interviewee was uncertain if both SASs use the same resources for their treatment groups.	depending on their stage of treatment. Training staff in a comprehensive stage-wise treatment model may help the team to maintain consistent service if SASs transition off the team. Optimally, consistent evidence-based co-occurring treatment is provided.

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			Some member treatment plans reviewed address substance use, such as information about group and individual substance use treatment in the services section. However, two applicable members' plans included sobriety-focused content. It was unclear if the information reflected the members' goals or staff's view.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff said that there are one or more employees on the team with personal lived experience of psychiatric recovery who share aspects of their story, when applicable. However, members interviewed were uncertain if any staff on the team have direct lived experience of psychiatric recovery.	• Ensure member voice is represented. Not all interviewees were aware if there is staff on the team with direct personal lived experience of psychiatric recovery.
Total Score:		**4**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	5
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	5
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	3

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	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4**	
Highest Possible Score	**5**	