ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 13, 2019

To: Wendy Rodgers, FACT 3 Clinical Care Coordinator
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AHCCCS Fidelity Reviewers

Method

On April 15-16, 2019, T.J. Eggsware and Annette Robertson completed a review of the Community Bridges Inc. (CBI) Assertive Community Treatment (ACT), Forensic ACT Team Three. 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.

Community Bridges, Inc. (CBI) operates several locations throughout Arizona. The services available to adults include supportive housing, crisis stabilization, ACT, and integrated healthcare. CBI operates five ACT teams, which includes two ACT teams located in Avondale, AZ, and three Forensic Assertive Community Treatment (F-ACT) teams. Since the last fidelity review, the agency F-ACT teams moved to a permanent office located in Phoenix, AZ.

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

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

- Observation of a daily F-ACT team meeting on April 15, 2019;
- Individual interviews with Clinical Coordinator (i.e., Team Leader), ACT Specialist (AS), Peer Support Specialist (PSS), and one of the team's Substance Abuse Specialists (SASs);
- Group interview with five members;
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of documents and resources, including the agency website; program brochure, *OUTREACH-Lack of Contact Checklist*, *ACT Operational Manual* and *F-ACT Admission Criteria,* developed by the Regional Behavioral Health Authority (RBHA); and resumes and training records for the SASs, Employment Specialist (ES), and Rehabilitation Specialist (RS).

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 fully staffed with 12 direct service staff to ensure an appropriate member to staff caseload ratio. Staff includes two SASs and two Nurses. Staffing is of sufficient size to provide necessary coverage to the 89 members served. Many employees on the team have direct lived experience of mental health recovery. Members said that staff sharing of lived experience makes them relatable.
- The majority of members received face-to-face contact with more than one F-ACT staff over a sample two week period.
- Interviewees reported that both Nurses provide clinic and community based services and are available to on-call staff over the weekend and after hours. The Nurses take a primary role in coordinating healthcare.
- 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.
- Staff reported that the team was directly involved in assisting the ten most recent members who experienced a psychiatric hospital discharge. Furthermore, staff reported that no members experienced a psychiatric hospital admission for the period of December 13, 2018 through February 1, 2019. System partners should evaluate what interventions the team implemented during that timeframe.

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

- Seek feedback from current staff on what retention efforts the agency can implement. The team is fully staffed, but experienced turnover in the last two years. If there are vacancies, seek to recruit qualified staff prepared to deliver ACT services.
- Provide ongoing training, guidance, and supervision to specialists so they can effectively cross-train ACT team staff. For example, with training and supervision, the Vocational Specialists will be better positioned to cross-train other staff on the team in best practices in employment support services.
- Evaluate what factors contributed to the decrease in community-based services from the prior year review. For example, evaluate what office-based activities or groups occur that were not in place or previously occurred in the community. Optimally, the majority of services, 80% or more, should occur in the community.
- Engage natural supports, on an average of four times monthly, as partners in supporting members' recovery goals. Seek training and guidance for staff to enhance strategies to work with members to identify their supports and how staff can involve those supports.
- Provide training to staff on stage-wise treatment, associated interventions, and strategies to engage members in individual and/or group treatment.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 89 members with 12 staff that provide direct services, resulting in a member to staff ratio of about 8:1 (excluding the Psychiatrist).	
H2	Team Approach	1 – 5 5	Staff said they have caseloads for paperwork tasks, but that they serve all members. Based on ten records reviewed, 90% of members met with more than one staff over a two-week period. Members interviewed said that they have contact with multiple staff, two or more during a recent week.	
H3	Program Meeting	1 – 5 4	Staff said that the program meeting is scheduled for one hour four days a week and an extra half hour on a fifth day to allow for more detailed discussion on members with unique or challenging needs. Staff attends meetings on the weekdays they are scheduled to work. During the morning meeting observed, the team discussed about 50 members. The meeting concluded at the top of the hour. Staff confirmed that the meeting observed was representative. The team reconvenes the next daily meeting and continues where the prior meeting ended. During the meeting, data points were identified for all members, such as special assistance or applicable stage of change.	• All members should be discussed during the team meeting, if only briefly to provide an update, but may be in-depth depending on their status. • Evaluate if the standard data discussed during the meeting are necessary or could be documented on a shared meeting log. The time saved reviewing those data points might allow for discussing more members. For example, the team may elect to document a member's stage of change on a shared log and an SAS would be tasked to notify the team if a change occurs. Other elements may infrequently change.
H4	Practicing ACT Leader	1 – 5 3	The CC estimated spending about 26% of her time providing direct member services. Examples of direct services rendered by the CC were found in ten member records reviewed. Most occurred in the community. Based on review of the CC's productivity report over a month, she provided direct services to members about 14% of the time.	• Optimally, CC's delivery of direct services to members should account for at least 50% of her time and be documented in the members' records. If new staff joins the team, supervision might include the CC mentoring them as they deliver services.
H5	Continuity of Staffing	1 – 5 2	Data showed that 15 staff left the team during the recent two-year timeframe and two additional Psychiatrists provided coverage, resulting in a 71%	• Optimally, turnover should be less than 20% over a two-year period. When possible, examine employees' motives for

Item #	Item	Rating	Rating Rationale	Recommendations
			staff turnover rate. Turnover was highest at the Employment Specialist, Psychiatrist positions, followed by Nurse and SAS.	resignation, and attempt to identify other causes for employee turnover.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 90% of staff capacity over the past year, with a total of 14 vacancies. One SAS and the ES positions were vacant for three months in the prior year.	• Fill vacant positions as soon as possible with qualified staff. In an effort to support retention, ensure staff receives training and supervision for their specialty.
H7	Psychiatrist on Team	1 – 5 4	The Psychiatrist is assigned to the team for three ten-hour days per week. Staff said during those hours the Psychiatrist has no other administrative responsibilities and is not known to provide services to members from other CBI programs. Staff said that the Psychiatrist attends the team meeting three days a week, is an active member of the team, is accessible to them, and will respond to texts or phone calls promptly. During the team meeting observed, the psychiatrist actively contributed to conversation, discussed member updates and collaborated for follow-up plans. The Psychiatrist provides services entirely via telemedicine utilizing interactive video, and participated in the meeting observed using that format. Staff reported most telemedicine contacts occur with members at the team CBI office with another staff, most often a Nurse, present to facilitate. No members interviewed voiced objections to telemedicine services and affirmed that the Psychiatrist is open to discussions to determine the most effective medications and that she encourages socialization and physical wellness.	• Due to the number of members assigned to the team, review options to increase the Psychiatrist's time with the team. The amount of time the Psychiatrist works with the team, with consideration for the member census, is reflected in the score. • Telemedicine may offer increased flexibility for staff to facilitate more Psychiatrist interactions in members' homes or other secured settings in their communities, rather than primarily requiring members to travel to the CBI office.
H8	Nurse on Team	1 – 5 5	There are two full-time Nurses assigned to the team. Neither has administrative responsibilities and they rarely provide services to other CBI members. Both Nurses work four ten-hour days	

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			and attend the team meeting on the weekdays they are scheduled to work. Staff reported that the Nurses are accessible, responsive, including after hours if needed. Each Nurse is assigned one weekend day of on-call availability to staff. Based on all multiple sources, nursing activities occur in the office and community. Examples include visits to day programs where members attend, facilitating telemedicine appointments with the Psychiatrist, treatment planning, educating other staff regarding medications, providing injections, health education with members, monitoring healthcare services, and healthcare coordination. Some members said that Nurses have visited their home.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team is staffed with two SASs. Based on interviews and their resumes, each SAS has more than one year experience providing substance use treatment. One SAS is a Licensed Master of Social Work and the second completed a Master of Social Work.	
H10	Vocational Specialist on Team	1 – 5 1	The ACT team is staffed with an ES who joined the team January 2019 and a RS who joined the team April 2019. Based on review of training records and resumes, it does not appear either staff has at least one year of training/experience in vocational rehabilitation and support related to assisting adults diagnosed with a SMI to locate and maintain employment in integrated work settings. The team's previous RS, who held the position for about nine months, transitioned to another role on the team. Based on review of that staff's training record, they had less than three hours of training related to employment services.	• Provide ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid members to obtain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, and follow-along supports. Although staff filled the role of RS and/or RS, there was little evidence of training or prior experience in assisting members obtain and maintain jobs in integrated settings.

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H11	Program Size	1 – 5 5	At time of review, with 12 direct service staff, the team fully staffed, and is of sufficient size to provide coverage.	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported most referrals originate with agents of the legal system and come to the team through the RBHA. F-ACT staff, usually the CC, meets with the potential new member for a screening using the RBHA's F-ACT Admission Criteria. The team discusses the screening results. The CC and Psychiatrist usually make the final decision if members join the team, with no mandates to accept admissions.	
O2	Intake Rate	1 – 5 5	In an effort to actively recruit members, staff said they requested and were authorized to pick-up potential F-ACT members, who are not affiliated with another clinic, at their release from incarceration to complete an intake. This new process reportedly helps to ensure a smoother transition. The CC reported screening 11 members the prior month. Monthly admissions to the team over the prior six months peaked at five members during the month of October 2018. There were zero admissions February 2019, one admission each month during November 2018 and March 2019, with two admissions each month for December 2018 and January 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric services and individual and group treatment for substance use. General psychotherapy/counseling is available and staff said no members receive services from other providers. It seems that the team provides most employment and rehabilitative support. Staff reported one member is in an employment program with another provider. Staff said the	• Monitor the number of members in staffed residences. Carefully evaluate members' circumstances, and housing options, before they are referred to staffed residences over more independent living with F-ACT staff support. Optimally, no more than 10% of F-ACT members are in settings where other social service staff provides support. • With the addition of a second vocational

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			team assists members with job searches and connects them to Vocational Rehabilitation. Some members interviewed were aware of staff that can assist them with employment. In a reviewed record there was an example of staff assisting the member to start their job search online. The team provides in-home services and assists members to explore housing options. One staff estimated a low of about 8% of members are in staffed residences but other staff estimated 22-29% of members are in staffed residences, including four or less in RBHA affiliated settings. Most members in staffed residences are in locations where they are required to participate in groups and/or day work. Members that are able to pay privately are exempted from the day work requirement. One staff estimated fewer than five members are in those settings, but other staff estimated up to 20 in those settings. During the team meeting observed, staff referenced members in staffed settings, or plans to explore placement options for about 24% of the 50 members discussed. Staff said that legal system representatives sometimes mandate members reside in a staffed location. It was documented in one record that a member posited living with a friend but F-ACT staff recommended a recovery home setting. It was not clear if the suggestion was based on the staff's knowledge of the friend, nor was it clear if staff processed with the member the pros and cons of either choice.	staff, and training in vocational supports that enable members to obtain competitive employment, the team should be able to enhance the scope of employment support service available through the team. • Review with staff the benefits of competitive employment in relation to Work Adjustment Training. Staff may also benefit from training on techniques and strategies related to job coaching and providing follow-along supports to employed members.
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the F-ACT team is available to provide crisis services, including responding to members in the community. Members interviewed confirmed that the team is available after business	• Update the team call sheet and disseminate the phone numbers of new staff to members.

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			hours. Staff provides to members a document with the on-call and staff phone numbers and days worked. Two staff work Sundays and four work Saturdays. The document provided for review did not include the new RS or a staff's position change.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff affirmed that the team was directly involved in assisting the ten most recent members who experienced a psychiatric hospital admission. Furthermore, staff reported zero members experienced a psychiatric hospital admission for the period of December 13, 2018 through February 1, 2019. Staff said they increased engagement with members over that period. Staff reported that they involve the Psychiatrist or a Nurse in admissions during business hours and work with members for voluntary admissions. When members are inpatient, staff said doctor-to-doctor contact between the inpatient and F-ACT Psychiatrist occurs. There was evidence of this during the team meeting observed and in records reviewed. In one record, the team Psychiatrist documented multiple messages left for an inpatient provider. Staff said they coordinate with hospital staff and visit inpatient members every 72 hours after admission. In records, an example was found of a member who experienced a hospital admission without evidence of team involvement. Additionally, for another member who was inpatient, staff did not document visits with them every 72 hours.	• 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. • The RBHA and CBI should evaluate what factors contributed to the F-ACT Three team successfully supporting members in their communities for the more than a month period with zero member psychiatric hospital admissions reported. Review if the engagement and supports provided by the F-ACT Three staff over that timeframe can be replicated.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that the team was directly involved in assisting the ten most recent members who experienced a psychiatric hospital discharge. In	

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			one record, staff documented contact with RBHA staff to discuss recommendations from the inpatient staff for residential treatment for a member. It was not clear if the member was in agreement; they previously declined a 30 day treatment program. Also, the team did not feel there was a medical need to justify the referral. F-ACT Team Three staff explained to RBHA staff the plan to assist the member's transition to their apartment. Staff said that most members meet with the F-ACT Psychiatrist on the day they discharge and that the team completes daily face-to-face contact with members for five days.	
O7	Time-unlimited Services	1 – 5 5	Staff reported two members graduated over the 12 months prior to review and projected three members are likely to graduate in the next 12 months. The transition plan is based on what each member wants (e.g., choice of provider).	• Ensure treatment plans reflect the specific transition plan for members. This might include reducing the frequency and/or intensity of contact over a period of time leading up to the graduation off the team.
S1	Community-based Services	1 – 5 3	Staff reported they spend the majority (75-85%) of their time in the community. In ten member records reviewed, a median of 50% of services occurred in the community. Staff contacts with members occurred in a variety of settings, including member's residences or day programs. It was not always clear if visits were planned ahead with members to ensure they would be at the location. Some members interviewed reported staff bring them grocery or retail shopping. Some staff oversee office-based groups. Most telemedicine Psychiatrist contacts with members occur in the CBI office with another staff facilitating the contact.	• 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. • Ensure all staff engages members in the community at a similar level as what was reported by staff interviewed. Re-evaluation of tracking mechanisms of staff community contacts may be useful.
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the year prior to review, one member transferred to another provider following a guardian's request. Two other	

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			members closed; one could not be located and the team determined one member could not be served. Interviewees confirmed that if members do not want F-ACT services, staff tries to re-engage members and problem solve for solutions.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff said when members are not in contact with the team they conduct four outreach attempts weekly, described as *electronic* and *physical* (i.e., community-based). Staff stated that the team follows an outreach checklist for at least eight weeks. Based on documentation and meeting observation, the team coordinates with formal supports, often Probation Officers or guardians. SAS staff documented telephonic outreach if members missed individual sessions. During the morning meeting observed, staff discussed outreach for members who were out of contact with the team. However, in records reviewed there were examples of gaps in documented outreach. For one member, staff called a member twice and sent a text over the course of more than two weeks. There was another period of more than seven days with only one phone outreach. The member experienced medical issues and missed appointments with the Psychiatrist. For another member, over more than a week period the only outreach documented was electronic, using websites to search the member.	• Carefully monitor contacts with members. Ensure community-based outreach occurs and is documented. Not all staff attends each meeting so they cannot convey all member contacts directly each weekday as a full group. It may be useful to assign one staff to review documentation in member records during the meeting to confirm recent member contacts so that the team can proactively assign staff to make contact in the event of lapses. One staff suggested assigning one staff as an outreach specialist to assume primary responsibility for those activities. • Consider revising the OUTREACH-Lack of Contact Checklist to prioritize actions staff should be completing within certain timeframes. Having a more clearly defined outreach policy may support the team in determining next steps in efforts to re-engage members.
S4	Intensity of Services	1 – 5 3	Based on review of ten records, the median intensity of face-to-face service time per member was around 71 minutes weekly. Three of the ten members received more than 120 minutes average of weekly service time. The content of certain progress notes seemed brief for the time	• 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.

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			documented.	
S5	Frequency of Contact	1 – 5 3	A median weekly face-to-face contact of 2.50 was found in ten member records, an increase from the prior year review. However, four members received two or fewer face-to-face contacts. Members who receive medication observation services had a higher rate of contact with staff.	• 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.
S6	Work with Support System	1 – 5 1	Staff estimates of members with informal supports ranged from a low of 25%; a mid-range of 45%, and a high of 90-95%. Staff affirmed that based on their knowledge, their interactions with informal supports, and documentation, that the team maintains about weekly contact with supports. During the morning meeting, staff discussed recent contact with informal supports, or plans to make contact, for five members. Had all members been discussed it is possible the number could have been higher. In ten member records reviewed the team documented one contact with an informal support over a month timeframe.	• Encourage members to identify and build natural supports. Discuss with them the benefits of involving their supports in their treatment. Educate informal supports about ways to support members' recovery. • The team may benefit from further training and guidance, through the agency and/or system partners, on strategies to assisting members in building and engaging natural supports. • Monitor accuracy of documentation of contacts with informal/natural supports in the member records.
S7	Individualized Substance Abuse Treatment	1 – 5 4	The number of members with a co-occurring diagnosis was requested. Two documents were provided, one that showed 67 members and one that showed 80 members. Staff was uncertain of the reason for the inconsistency. F-ACT staff based their accounting of individualized treatment on the 67 member roster. Staff discussed members' stages of change during the meeting observed. There were few references to individual treatment but neither SAS was present. Sample member calendars were collected for 20 members. There were references to individual substance use treatment, but based on those calendars, no applicable members	• Staff should continue to offer individual treatment to members with a co-occurring diagnosis. Consider exploring training on strategies to engage members in substance use treatment.

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			participated in weekly. Staff said the SASs provide individual treatment, with the longer serving SAS working with more members than the second SAS. Examples were found in records of the SASs providing individual substance use treatment. It does not appear the average session exceeds 24 minutes per member. One SAS said about 42% of members that she primarily works with participate in individual treatment weekly for about 30 minutes. Sessions documented in records lasted nearly 30 minutes, with some exceptions. For example, an SAS worked with a member to complete paperwork so a portion of their contact time was not factored as treatment. In another example, a session lasted 45 minutes with a member who experienced a recurrence of use.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	One F-ACT Team Three SAS offers a group, open to all members from the team, focused on overall wellness. Substance use recovery does not appear to be a focus so the group was not factored when tallying member co-occurring treatment. Staff said that the other SAS offers two weekly co-occurring groups. One of those groups is co-facilitated by a SAS from F-ACT Team Three and an SAS from another F-ACT team. Each staff documents services for the members from their teams. Members from the 80 member roster, not listed on the 67 member roster, participated in group substance use treatment. The two rosters resulted in a range of 12-15 members who attended group treatment. About 19% of members with a co-occurring diagnosis from the 80 person roster attended group and about 18% of the 67 member	• 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 co-occurring groups. Provide guidance to all staff on strategies to engage members in treatment. • Evaluate the practice of staff co-facilitation where staff document interactions only for members from their teams, whether staff should document contacts with all members with whom they interact, and how those exchanges should be tracked (e.g., referenced in notes as co-facilitators or entered as non-billable contacts). Review whether the F-ACT Team Three SASs can co-facilitate rather than co-

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			roster participated.	facilitating with staff from other teams.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Based on interviews, observation and documentation, it appears that staff generally use a harm reduction approach. Staff gave examples of recent harm reduction efforts, such as working with members to alter their use to mitigate the chances of losing housing, employment, or incarceration. Staff gave examples of the team using or arranging for medication-assisted treatment. However, one staff documented in multiple records that sobriety was recommended. Additionally, it does not appear all staff are familiar with stage-wise treatment. Most applicable plans reviewed referenced substance use treatment by a SAS, with goals, needs and objectives that varied from member to member. During the team meeting, staff identified the stage of change for members who have a co-occurring diagnosis. Staff said they do not refer members to Alcoholics Anonymous (AA) or similar groups, but will seek to match members with an option if the member requests. Staff cited situations when detoxification may be medically indicated, due to certain substances used.	• Provide regular guidance to staff in a stage-wise approach to treatment in relation to the stage of change approach. Training staff about stage-wise treatment interventions may help them to align their activities appropriately. • Review with staff to ensure accurate documentation of efforts supporting members in reducing use and employing harm-reduction tactics in place of a standard recommendation of sobriety.
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff said many employees on the team have direct lived experience of mental health recovery. Members affirmed that there are staff on the team with lived experience of mental health recovery, substance use and/or experience with the legal system. Members reported staff share with them and their lived experience make them relatable.	
Total Score:		**3.93**		

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	4
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	1
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	5

7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	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	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.93**	
Highest Possible Score	**5**	