ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: September 16, 2019

To: Aaron Sorenson, FACT-1 Clinical Coordinator
Dr. Cassandra Bank
John Hogeboom, President/CEO

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

Method

On August 19-20, 2019, T.J. Eggsware and Annette Robertson completed a review of the Community Bridges, Inc. (CBI) Forensic Assertive Community Treatment (F-ACT) Team One. 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. Services include supportive housing, crisis stabilization, ACT, and integrated healthcare. The agency operates three F-ACT teams and three ACT teams. The F-ACT teams moved to a new location since the prior review of F-ACT Team One, the focus of this review.

The individuals served through the agency are referred to as *clients*, *patients* and *members*, 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 August 19, 2019;
- Individual interviews with the Clinical Coordinator (i.e., Team Leader), a Substance Abuse Specialist (SAS), the ACT Specialist (AS), and the Rehabilitation Specialist (RS);
- Group interview with five 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 and resources, including: the Regional Behavioral Health Authority (RBHA) *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual*; *F-ACT Admission Screening* tool; CBI program descriptions document; F-ACT program description flier, Clinical Coordinator (CC) face-to-face tracking log for a recent month; sample member calendars; the team contact flier; substance use group sign-in sheets; and resumes and training records for the SASs, Employment Specialist (ES), and the 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 staffed with a Psychiatrist and 11 direct service staff, including two Nurses, resulting in a member-to-staff ratio of about 9:1. Staffing is of sufficient size to provide necessary coverage to the 98 members served.
- Staff practices a team approach to service delivery. Staff tracks completed and planned contacts with members using calendars during the daily team meeting. In records reviewed, staff documented a high intensity of service time with members.
- Staff said that the Psychiatrist and Nurses are accessible. The Nurses attend the team meeting on the weekdays they are scheduled to work, and the Psychiatrist attends at least twice per week.
- The ACT team provides crisis support to members. Most members interviewed confirmed that the team is available after business hours by phone and can meet members in the community. The Psychiatrist and one Nurse are scheduled to work on Sunday, and one Nurse is on-call for staff to contact after hours or over the weekend, if necessary.
- The team maintained consistency and continuity of care for members, with a low team admission rate, and few members transitioned off the team over the year prior to review.
- During the team meeting, staff discussed members' ability to address medical conditions. Similar examples of engagement and support were found in member records reviewed.
- The agency website offers a brief description of ACT services and the agency care access line.

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

- Reduce staff turnover to no more than 20% in 24 months. 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. Agency administrators may consider seeking input on how agency or program changes impact direct service staff. Consider providing more specialist specific training to each staff.
- Develop engagement plans in advance with members who are known to self-admit to inpatient settings without contacting the team. More contact with members' informal support networks might result in the identification of issues or concerns that could lead to hospitalization. Ensure all members and their supports receive the flier with team contact names and numbers.
- Increase community-based services so that 80% or more occur in the community. When possible, seek to shift services from the office to the community, with a focus on increased weekly contacts with members to average four or more. Consider eliminating or modifying activities that result in staff needing to spend time in the office.

- Educate members on the benefits of natural supports and assist members in building and identifying those supports. Engage natural supports as partners in supporting members' recovery goals. For example, assist supports to identify community-based activities to engage in with members. Training staff on informal support engagement strategies may be helpful. Staff may be able to draw from training to give informal supports tips on how to reinforce healthy recovery behaviors or to model recovery language when interacting with members.
- 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. Consider adopting a co-occurring treatment model for continuity of care.

ACT FIDELITY SCALE

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 about 9:1.	
H2	Team Approach	1 – 5 5	Staff is assigned caseloads for paperwork purposes but appear to function with a team approach. Members said that they received face-to-face contact from three or more staff during the week prior to review and confirmed their ability to contact multiple staff on the team for support. Staff estimated that about 91% of members receive face-to-face contact with more than one staff over a two week period. The review of ten records showed 90% of members received contact from two or more staff over two weeks.	
H3	Program Meeting	1 – 5 4	Staff said that the team meeting is scheduled five days a week, usually lasting one hour. If all members are not discussed, the team begins the next meeting in reverse order to discuss the remaining members. On Wednesdays staff discuss members experiencing more serious issues. Not all members are discussed at the meeting. The observed meeting lasted more than an hour and all members were discussed. The Program Assistant played an active role in facilitating the program meeting. Staff discussed recent contact, planned follow-up, and staff assignments. For applicable members, staff identified special assistance, stage of change, and due paperwork.	• All members should be discussed during the regular team meeting, if only briefly to provide an update, but discussion may be more in-depth depending on their status. • Evaluate if the standard data points discussed during the meeting are necessary or can be documented on a shared meeting log. The time saved reviewing the data points might allow for more member discussion. For example, the team may elect to document a member's stage of change on a shared log. An SAS can be tasked to notify the team of changes. Other elements may infrequently change.
H4	Practicing ACT Leader	1 – 5 3	The CC, who assumed the position June 2019, estimated spending about 19-20% of the time providing direct services to members. Based on review of the CC's productivity report over a recent month, direct services were provided to	• Optimally, CC's delivery of direct services to members should account for at least 50% of the time and be documented in the members' records. Seek to balance direct service with other job duties. For example,

Item #	Item	Rating	Rating Rationale	Recommendations
			members about 19% of the time. Examples of office and community-based services delivered by the CC were found in member records.	if new staff joins the team, supervision might include the CC mentoring them as they deliver services.
H5	Continuity of Staffing	1 – 5 3	Data shows that 13 staff left the team during the recent two-year timeframe, resulting in a 54% turnover rate. Turnover was highest for the SAS position, but multiple staff also filled the roles of ES, Housing Specialist (HS), Independent Living Specialist (ILS), and Peer Support Specialist (PSS).	• When possible, examine employees' motives for resignation, and attempt to identify causes for turnover which optimally should be less than 20% over a two-year period. Consistent staffing is a key ingredient in successful ACT teams.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 90% of staff capacity over the past year. There was a total of 14 months with position vacancies. The ES, AS and SAS positons were inconsistently filled. Some staff said that turnover in the prior year added to their stress, but that staffing and team morale improved over the past few months.	• Consider evaluating employees' motives to maintain employment with the team, retention efforts they might be receptive to, how the agency can support them in their roles, and how agency or program changes impact direct service staff.
H7	Psychiatrist on Team	1 – 5 5	Staff said that Psychiatrist is available to members 40 hours a week, attends the program meeting two days a week, and has no other administrative duties. Over the past year the Psychiatrist rarely provided services to members from other CBI programs. Members affirmed that the Psychiatrist is open to discussing how to best help them. Staff said that the Psychiatrist's weekly work schedule is 10-12 hours a day on Sunday, Tuesday, Thursday and Friday. Staff said that the Psychiatrist may alternate Thursday or Friday availability. On Thursdays the Psychiatrist meets with members via video (i.e., telemedicine). The Psychiatrist occasionally provides services in the community. A staff said that the team found it more beneficial to have the Psychiatrist at one location.	• Ensure that the Psychiatrist is assigned to the F-ACT Team One 100% of the time if the team census remains near or reaches 100 members. Optimally, the Psychiatrist regularly provides community-based services.
H8	Nurse on Team	1 – 5 5	Two full-time Nurses are assigned to the team. Neither Nurse has other administrative responsibilities. The Nurses rarely provide services	

Item #	Item	Rating	Rating Rationale	Recommendations
			to members from other CBI programs. Staff reported that the Nurses are available when needed, that each works four ten-hour days, and attend program meetings on the weekdays they are scheduled to work. One Nurse is scheduled to work on Sunday, and one is on-call for staff to contact after hours and weekends, if necessary. The Nurses coordinate medical services, perform traditional nursing services, and assist with case management. There were examples in records of the Nurses providing community-based services.	
H9	Substance Abuse Specialist on Team	1 – 5 5	Two SASs work on the team. One, a Licensed Master of Social Work (LMSW), joined the team June 2018. The second SAS started April 2019 and has a degree in Professional Counseling. Staff said that the SASs receive roughly weekly individual and monthly group supervision. The SASs alternate providing weekly substance use treatment clinical oversight to the team. Based on interviews and resumes, each SAS has more than one year experience providing substance use treatment.	
H10	Vocational Specialist on Team	1 – 5 4	The team employs an RS who has been with the team since March 2016 and an ES who joined the team in May 2019. Training records showed both participated in few employment support service trainings since joining the team. In a prior position, the RS assisted individuals with interviews, resumes, and resources to obtain employment. In addition to time on the team, the ES was a volunteer for about three years and assisted individuals with applications, interviews and employment searches.	• In an effort to support retention and as part of career development, ensure both vocational support staff receive supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings. Ideally training topics include strategies to engage members to consider employment, job development, supporting individualized job searches, and directly providing follow-along support.
H11	Program Size	1 – 5 5	At the time of review, with 12 direct service staff, the team is of sufficient size to provide coverage.	

Item #	Item	Rating	Rating Rationale	Recommendations
O1	Explicit Admission Criteria	1 – 5 5	Staff said that most referrals originate from representatives of the legal system, such as Probation or Parole Officers, or Arizona Department of Corrections staff. The CC, or an experienced staff, meets with the potential new member to complete the RBHA's screening tool. The Psychiatrist reviews the findings and makes the final decision if members join the team, with no external mandates to accept admissions.	
O2	Intake Rate	1 – 5 5	Monthly admissions to the team over the six months prior to review peaked at six members during July 2019. There were five admissions June 2019, four during February 2019 and one each month during March, April and May 2019. It appears there were fewer admissions during months when there were multiple vacant positions on the team.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides case management, psychiatric services, and substance use treatment. Psychotherapy/counseling and employment services are available. Few members receive counseling through the team aside from substance use treatment. During the team meeting, and documented in records, there were examples of staff supporting members with employment goals or encouraging members to identify a socialization or employment goal. However, in a clinical oversight document it indicated staff discussed available vendors to assist members with employment goals. During the program meeting, staff discussed helping certain members with housing searches and others with retention. The types of interactions discussed and documented in notes	• Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff support. Discuss with members their alternative independent living options where the F-ACT team can support them. Optimally, no more than 10% of ACT members reside in settings where other social service staff provides support. • Due to discrepancies in reporting of members who reside in staffed settings, it may be useful to discuss all members in non-independent settings and what rules or conditions are in place for those members in those settings. The discussion may include any settings where members do not hold a lease, unless residing with

Item #	Item	Rating	Rating Rationale	Recommendations
			included independent living skills assistance, reviewing budgets, and taking members shopping. However, more than 10% of members are in staffed residences. Staff accounts of the types of staffed settings varied, ranging from a low of seven to a high of 26. A tracking document showed five members in residential treatment situations; one in an independent setting where brokered staff provide services; and, 14 members reside in half-way-house settings. Staff described those settings as places where resident staff are present and may help residents to manage appointments, enforce living arrangement rules, require drug testing, or will inform the team if a member experiences a crisis. Staff said that one member receives Permanent Supportive Housing services through another agency.	family. • 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. • Ensure members and stakeholders are aware that counseling/psychotherapy is available through the team and that ongoing supervision is provided to staff that provide that service. • Ensure both vocational support staff receive supervision and training to directly assist members to find and keep jobs in integrated work settings rather than relying on vendors.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team is available to provide crisis service 24 hours a day, seven days a week, including meeting members in the community if needed; staff reported that prior to responding to crisis calls they first go to the CBI office to obtain a company vehicle. Some staff work weekend shifts, including a Nurse and the Psychiatrist. A Nurse is on-call for staff to contact outside of regular business hours if necessary. Staff provides to members a document identifying the team on-call number, staff names, positions, phone numbers, and email addresses.	• Consider enhancing the team contact sheet by adding staff hours of availability and brief position descriptions. • Ensure that the need for staff to go to the CBI office to obtain a company vehicle does not result in delayed response to members experiencing a crisis after hours. Consider monitoring response times.
O5	Responsibility for Hospital Admissions	1 – 5 4	Based on data provided, the team was directly involved in eight of the ten most recent hospital admissions. Staff said that if a member requests inpatient services, staff will arrange for members	• When members do not involve the team prior to an admission, seek to identify the reasons or their circumstances. To the extent possible, develop plans with the

Item #	Item	Rating	Rating Rationale	Recommendations
			to meet with the team Psychiatrist for assessment in person or via telemedicine. On-call staff is available after hours and on the weekend.	members and their support systems so the team can inform them how staff can offer support.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said that the ACT team is always involved when members discharge from the hospital. Staff said the Psychiatrist attempts doctor-to-doctor calls to inpatient providers unless the member is receiving the service from another CBI facility. For those members, the Psychiatrist can review notes in the integrated record system and other specialists coordinate care. Staff reported that an ACT staff meets with members within 24 hours of an admission and then every 72 hours thereafter. Staff meets with members at discharge to transport them to their discharge setting. Ideally the member meets with the Psychiatrist on the day of discharge, but if not, then an appointment occurs within 48 hours. If needed, the team will assist with primary care follow up appointments within 30 days of hospital discharge. The team conducts five consecutive days of face-to-face contact with members after discharge.	
O7	Time-unlimited Services	1 – 5 4	The ACT team reported that eight members graduated from the team over the prior year. Staff estimated about six members as potential graduates in the next 12 months. Staff said that they work with members to revise the member's treatment plan, reducing the frequency of contact over a period of time leading up to the graduation.	• Continue to work with members to determine whether they are prepared to transition from ACT services. Ensure members are not transitioned prematurely. Use a graduation rate of fewer than 5% as a threshold.
S1	Community-based Services	1 – 5 3	Staff reported that they spend the majority (80-85%) of their time in the community. Staff said that if they facilitate an office-based group, they likely spend more time in the office on that day. Certain members reported they often meet with staff at the office or to participate in office-based	• Evaluate barriers to increasing community-based services. 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

Item #	Item	Rating	Rating Rationale	Recommendations
			groups. Some members reported a mix of about 50% office and 50% community contacts. Records showed a median of 56% of community-based services.	natural, non-clinical setting. Engage members in the community at a similar level as what was reported by staff.
S2	No Drop-out Policy	1 – 5 5	Interviewees said that if members do not want ACT services, staff discuss the member's status, and adjusts the treatment plan if the member prefers fewer contacts or is in process to transition to a less intensive team. Based on data provided for the prior year, the team retained about 97% of members. Staff reported that one member closed, and three left the geographic area without referral, but one subsequently returned to the team. Members confirmed that ACT is voluntary.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff reported that the team follows the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual* to guide their outreach. When members are not in contact with the team, staff conduct outreach for eight weeks and then members transition to *Navigator* status. Staff conducts at least four weekly attempts, two of which are conducted from the office and two in the community. In most reviewed records, staff documented frequent contact or outreach to members. Staff coordinates care with formal supports such as guardians, advocates, representative payees, and representatives of the legal system. Staff discussed collaborating with formal supports during the program meeting.	
S4	Intensity of Services	1 – 5 5	Based on review of ten records, the median intensity of face-to-face service time per member was about 125 minutes weekly. The team provided an average of 120 minutes or more weekly to seven of the ten members.	
S5	Frequency of	1 – 5	A median weekly face-to-face contact of 3.75 was	• Continue frequent staff face-to-face

Item #	Item	Rating	Rating Rationale	Recommendations
	Contact	4	found in ten records reviewed. The team provided an average of four or more face-to-face contacts to five of those ten members. During the team meeting, the CC and staff discussed and planned who would make contact with specific members.	contact with members with an emphasis on community-based individualized support. Optimally, an average of four or more weekly face-to-face contacts with members occurs.
S6	Work with Support System	1 – 5 2	The agency offers a monthly family forum open to ACT and F-ACT members' supports that meets for an hour during the evening. Staff estimates members with informal supports were 20% to a high of 40-50%. Staff said that the team is in contact with informal supports, on average, weekly, but the frequency can vary based on how involved the support is in the member's life. During the program meeting, staff discussed recent contact with informal supports, or planned contact, for ten members. In ten records, a total of nine contacts with informal supports were documented over a recent month period.	• Discuss with members the benefits of involving their supports in their treatment and assist in identifying and building those supports. • Increase engagement of natural supports as partners in supporting members' recovery goals. Staff may benefit from training on how to engage informal supports. 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	Individualized substance use treatment is available through SASs on the team. Each SAS is assigned 35 applicable members for individual treatment and the eight other members are divided among the staff on the team for outreach and engagement. Staff reported that some members usually receive about 30-minute weekly sessions. Sample calendars showed 18 of 20 members with a substance use diagnosis. Of those, four members received zero individual sessions but five received four to five sessions. Remaining calendars showed one to three sessions, but certain members declined or did not attend sessions. Seven of the ten records reviewed were for members with a substance use diagnosis. Over the	• Continue efforts to engage applicable members in individual substance use treatment with the goal of achieving a weekly average of 24 minutes or more of individual treatment per member. • Train staff on strategies to engage members in substance use treatment. Individualized treatment may be more appropriate for members in earlier stages of treatment. • Ensure that both SASs receive the necessary training, mentoring, and ongoing guidance to provide structured, individual substance use counseling. Consider adopting a formal co-occurring treatment model.

Item #	Item	Rating	Rating Rationale	Recommendations
			course of a month, two members received two individual sessions each; three sessions were documented for three other members; one session was documented in one record and no sessions were documented in one record.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	One SAS offers two weekly treatment groups. A Friday group is targeted to members in earlier stages and a Thursday group for those in later stages of recovery. There were examples of applicable members attending group treatment in records reviewed. Based on sign-in sheets, over a month timeframe, about 21% of pertinent members attended group. A few who attended were listed on the full member roster but not the list of individuals with a substance use diagnosis. Based on interviews, members in remission are not included in the number of members with a substance use diagnosis so their participation in group treatment was not factored.	• 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, or any other staff who facilitates group substance use treatment, receive the necessary training, mentoring, and ongoing guidance to provide structured group treatment to members with substance use diagnosis.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Applicable service plans included individualized member content, substance use challenges, and treatment such as monitoring of potential interactions between substances and prescribed medications, or member interactions with an SAS. Staff gave examples of recent harm reduction efforts. Staff reported that the team supports members with harm reduction rather than focusing on abstinence, consistent with the program meeting observation. However, in multiple records a staff documented members should refrain from substances and some staff documented that members were *clean*. Staff said that the team does not refer members to Alcoholics Anonymous (AA) or similar groups.	• Consider adopting a formal co-occurring treatment model. Utilizing various substance use treatment materials or a mix of other selected approaches does not equate to an evidence-based co-occurring model. • Using a standard co-occurring treatment model may allow for continuity of care if SASs transition off the team. Exiting SASs may be positioned to cross-train newer SASs on the treatment model used and staff can draw from the same treatment resources. There was the most turnover at SAS in the two years prior to review. • Staff may benefit from specific training on how stage-wise treatment (i.e.,

Item #	Item	Rating	Rating Rationale	Recommendations
			Certain members may be required to participate through their residence as a condition of the residence agreement and/or as a term of their probation or parole. If members experience a recurrence of use, staff at certain settings may require them to receive detoxification service for medical clearance before returning to the residence. Staff reported they generally do not refer for withdrawal management since most members with a co-occurring diagnosis use methamphetamine. Fewer members use substances that may require medical withdrawal monitoring. Staff gave examples of those substances. Staff said that they draw from their training in Motivational Interviewing, Integrated Dual Disorder Treatment (IDDT), and from SAMHSA materials. Staff said the team is trained in identifying members' stage of change and applying corresponding interventions. However, it is not clear if the team follows a standard, formal treatment approach. Clinical oversight tracking was provided that showed staff discussed a variety of topics, but not IDDT recently. Staff appear to be familiar with stages of change, but it is not clear if all are familiar with stage-wise treatment.	engagement, persuasion, active treatment, and relapse prevention) relates to stages of change. • Consider training staff on how to incorporate recovery language in documentation and, if necessary, during interactions with members. For example, rephrasing member progress toward recovery or reduction of substance use if the member uses non-recovery language.
S10	Role of Consumers on Treatment Team	1 – 5 4	Interviewees confirmed there are employees on the team with direct lived experience of substance use recovery and/or periods of homelessness. Staff were uncertain if any current staff has direct lived experience of mental health recovery.	• Ideally, member perspective is represented on the team with one or more staff with direct lived experience of psychiatric recovery.
Total Score:		**4.25**		

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	3
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	4
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	4
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	5
4. Intensity of Service	1-5	5
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	4
Total Score	**4.25**	
Highest Possible Score	**5**	