ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: March 22, 2016

To: Gail Salentes, MACT Clinical Coordinator
Michaela Hickman, Site Director

From: Georgia Harris, MAEd
T.J. Eggsware, BSW, MA, LAC
ADHS Fidelity Reviewers

Method

On February 16-17th, 2016, Georgia Harris and T.J. Eggsware completed a review of the Partners In Recovery-Arrowhead 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 Maricopa County.

The Partners In Recovery Network (PIR) serves individuals with Serious Mental Illness (SMI) through five locations in Maricopa County: Metro, West Valley, Hassayampa (Wickenburg), East Valley, and Arrowhead. Each of these locations provides services such as Psychiatric, Case Management, Transportation, Interpreter Services, and Health & Wellness Groups. On February 1, 2015, the PIR-Arrowhead Campus established a specialty ACT team, the Medical ACT or M-ACT team. The M-ACT team is focused on serving members who are both ACT-eligible and deemed "medically compromised" through a qualifying medical diagnosis. The M-ACT team will be the focus of this report. The M-ACT team was scheduled for relocation to a new office the week after the review, where the M-ACT team, the M-ACT Psychiatrist and the assigned Primary Care Physician (PCP) will be exclusively located.

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 activities:

- Observation of a daily M-ACT morning team meeting on February 16, 2016;
- Individual interview with team leader (ACT Clinical Coordinator or M-ACT CC);
- Individual interviews with the Substance Abuse Specialist (SAS), the Independent Living Skills Specialist (ILS) and the Rehabilitation Specialist (RS);
- Individual interviews with three (3) members receiving M-ACT services;
- Charts were reviewed for 10 members using the agency's electronic medical records system;
- Reviewed agency documents provided by M-ACT Staff: *Case Closure and Re-Engagement Activities Prior to Disenrollment* policy;

introductory lesson to the *Integrated Dual Disorders Treatment Recovery Life Skills Program*; the PIR-Arrowhead class/group schedule; *Matching Stages of Change and Treatment to Treatment Goal Intervention and Technique* handout; M-ACT CC *Provider Productivity* summary report; sample M-ACT CC's staff face-2-face tracking form, *Medical-ACT Admission Screening* criteria; *M-ACT morning meeting Log and the M-ACT Hospitalization Report.*

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:

- In addition to the full spectrum of psychiatric care, the team Psychiatrist participates in intense clinical coordination with the M-ACT staff and assigned PCP. In addition, the Psychiatrist's detailed clinical reporting provides treatment context and clear guidance on treatment activities.
- The team has well-established admission criteria. It befits the team to only accept members whose circumstances most closely align with both the medical and ACT requirements for service.
- The team has two Registered Nurses (RNs). Though both are able to provide services to all members, each RN has an area of specialty on the team; one designated for medical coordination, the other for psychiatric coordination.
- The team benefits from a fully-integrated Peer Support Specialist (PSS), who provides support related to therapeutic rapport, is cross-trained and effectively provide services in other ACT specialties (e.g. Substance Abuse), and co-facilitates a family group at another PIR facility one night a week.

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

- The team should be equipped with an adequate number of qualified Substance Abuse Specialists (SASs) to meet the treatment needs of the members. SAS staff should be able to provide all aspects of Dual Diagnosis treatment; moreover, they should provide consultation to other M-ACT Staff who are being cross-trained in this specialty.
- The team does not have an established dual-diagnosis treatment group. The team should prioritize the creation and regular offering of M-ACT-exclusive weekly groups. Groups that are focused on dual-diagnosis (DD) principles may improve members' recovery outcomes. Engage members with substance use challenges to participate in individual and group treatment delivered through the team.
- The majority of ACT services are being performed in the clinical settings. Revisit strategies for providing community-based care for members. ACT services are designed to be provided primarily in the community. When skills are taught in their most naturally-occurring environment, they are better retained.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team maintains a low member to staff ratio. The team serves 58 people. The ratio of members to staff is approximately 6:1. The team roster consists of the following positons: an M-ACT Clinical Coordinator (M-ACT CC), a Substance Abuse Specialist (SAS), a Rehabilitation Specialist (RS), an Employment Specialist (ES), an Independent Living Skills Specialist (ILS), a Housing Specialist (HS), two Nurses (RNs), a Peer Support Specialist (PSS) and a M-ACT team Specialist. This count excludes the Psychiatrist and any administrative support.	
H2	Team Approach	1 – 5 5	The team shares responsibility for members and contributes expertise when appropriate. During the M-ACT morning meeting, reviewers observed the sharing of updates on member statuses and treatment recommendations. Approximately 90% of the ten randomly-selected member records indicated that members had face-to-face contact with multiple staff members, in a two-week period.	
H3	Program Meeting	1 – 5 5	The team meets for their morning meeting Monday through Friday, from 9:30am to 11:00am, to discuss and coordinate care for all M-ACT members; all staff is present unless they have flex-schedules. For example, the Psychiatrist attends the morning meetings four days a week; he is absent from the Monday meeting due to his scheduled flex-day. Since the M-ACT team has a medical specialty, the assigned Primary Care Physician (PCP) attends the morning meeting every Wednesday. Staff described both the PCP and Psychiatrist as equal contributors, jointly providing direction to staff during the team	

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			meetings.	
H4	Practicing ACT Leader	1 – 5 3	The M-ACT CC routinely provides backup services to M-ACT members. The M-ACT CC estimated that approximately 50% of her time is spent serving members; she is regularly scheduled for medication observation routes and visits members residing in ACT houses. The member record review revealed some face-to-face interactions between members and the CC. Upon review of the CC's productivity report, it was shown that the CC was meeting with members approximately 25% of the time. It was also noted that this calculation was based off of billable units of time and not the actual time spent with members; this lends reviewers to assume the supervisor provides services routinely, or as backup, less than 25% of the time. Some of the CC's time may be accounted for by screenings of potential member admissions to the team, which is not factored into consideration on this item.	• The team supervisor should provide services at least 50% of the time. While the team has a low member to staff ratio, the CC should seek opportunities to establish direct rapport with members so that those relationships can be maintained as the census increases. There may be opportunities for the CC to model interventions or provide guidance to staff in the field during member interactions. • Review CC administrative tasks to determine if any of those can be transitioned to other staff at the clinic or agency to allow the CC more time to provide direct member services.
H5	Continuity of Staffing	1 – 5 4	The M-ACT team has maintained a relatively consistent staff roster over the past year. The team experienced a 33.3% turnover in positions over the past year. Vacancies were experienced in the CC, SAS, ILS and RS positions. All of these vacancies are currently filled and the team is working towards hiring additional staff.	• Continue working with the agency management to thoroughly examine position applicants to confirm they are the best fit for the position and the demands of an ACT level of service.
H6	Staff Capacity	1 – 5 3	In the past 12 months, the M-ACT team has operated at approximately 76% of full staffing capacity. Reviewers experienced some incongruity in data reported for this item. The team reported four positions that experienced turnover over the past 12 months: the SAS, CC, ILS and RS. The team currently has 11 staff; however, reviewers were informed that the team gradually added staff	• As the team continues to grow, ensure that both new and current staff are not only trained in their areas of specialty, but are cross-trained in other ACT specialties, to ensure continuity of care when vacancies arise.

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			incrementally throughout the year. Given that the team was designed (and continually strives) to be a 100-member team, with 12 staff, the intended structure was factored into the scoring of this item.	
H7	Psychiatrist on Team	1 – 5 5	The team has one, full-time Psychiatrist. The Psychiatrist provides treatment, medication prescription and monitoring for M-ACT members. The Psychiatrist attends the morning meetings four days a week; he is absent from the Monday meeting due to his scheduled flex-day. The staff affirmed that the Psychiatrist is intensely involved in treatment coordination with the team's assigned PCP. Reviewers noted multiple member records where detailed clinical reporting was authored by the Psychiatrist.	
H8	Nurse on Team	1 – 5 5	The team benefits from having two Nurses (RNs) on staff. The RNs' responsibilities are assigned in accordance with their professional fortes; one Nurse assumes primary responsibility for providing psychiatric care, while the other is given charge of more intense medical and (PCP) coordination. RNs meet with members in the community as well as in the clinic. Members also voiced their familiarity with the RNs and their roles on the team.	
H9	Substance Abuse Specialist on Team	1 – 5 2	The team has one full-time SAS, who has been in the position for two months. The SAS has taken some recovery-centered coursework in her degree program and has been engaging in training opportunities offered by the provider agency. The SAS has worked extensively with the youth population; however, this is her first time working with adult members. One of the clinic administrators is a Licensed Independent Substance Abuse Counselor (LISAC); she provides	• Consider recruiting an additional SAS with the credentials and/or training to provide all aspects of Substance Abuse treatment (e.g., Substance Abuse counseling) • Ensure that all staff have at least one year of training or clinical experience in substance abuse treatment.

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			intermittent counseling support to members and supervision to the SAS but is not a full-time SAS on the team.	
H10	Vocational Specialist on Team	1 – 5 3	The team currently has two Vocational Specialists: one Employment Specialist (ES) and one Rehabilitation Specialist (RS). The ES has worked in this capacity on multiple M-ACT teams in the past few years. The RS is new to the position; she has worked on M-ACT teams in the past as an Independent Living Skills Specialist but has not worked in the RS capacity. For training, both staff regularly attend the specialty-specific trainings offered by the RBHA, but it is not clear if both staff have training and experience in vocational services that enable members to find and keep jobs in integrated work settings.	• Ensure that all staff have at least one year of training or experience in vocational rehabilitation and support.
H11	Program Size	1 – 5 5	The M-ACT team consists of 11 full-time staff. The program is sufficient size to provide necessary staffing coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The team operates from a well-defined admission criteria. The team uses the Medical-ACT admission criteria (as outlined by the RBHA) as the primary source for screening. The Medical-ACT standards consist of the basic qualifications for ACT admission in the RBHA, with the additional requirement of a qualifying medical diagnosis. Examples include: diabetes, cardiovascular disease, and Chronic Obstructive Pulmonary Disease (COPD). The M-ACT Staff reported that the types of medical ailments monitored by the team are limited to those that can be measured in a relatively unambiguous manner (i.e. blood glucose levels in diabetes patients). The team reports no administrative mandate to admit members to the team that the team assesses as not appropriate;	

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			the team makes the final determination.	
O2	Intake Rate	1 – 5 5	The team intakes new M-ACT members at a low rate. The M-ACT team reports 25 admissions in the last six months. The team's highest intake months were October and November 2016 with six admissions each.	
O3	Full Responsibility for Treatment Services	1 – 5 3	The M-ACT team maintains full responsibility for two of the five additional ACT services. In addition to case management, the team fully provides psychiatric services, and housing/ILS support. Staff acknowledged that they do not provide counseling/psychotherapy because none of them are licensed in that capacity. The team partially provides substance abuse treatment. Members receive substance abuse counseling/treatment in an unstructured format, often through primary staff assigned, during regular home visits. Though the team provides some aspects of vocational services, less than 10% of the members are participating in vocational services. The support through the team tends to focus on pre-employment activities (e.g., resume building, personality development, computer skills group).It was reported that four members are engaged with vocational services; one is participating in a work adjustment training (WAT) program; other members found work on their own, and a small number work with vocational staff to explore employment.	• Evaluate the current engagement strategy for tracking member participation in ACT specialty services. Consider tracking the documentation of attempts to offer services and revisit the engagement strategy habitually. • Some teams elect to review service delivery by specialty staff position during the team morning meeting; this approach may help to bolster the specialty staff support and interventions on the team. • The agency, in collaboration with the RBHA, should continue to review training and supervision options to ensure staff designated with a specialty area receives monitoring, support, and supervision specific to their role. See also recommendation for H9 and H10 regarding training of SASs and vocational staff.
O4	Responsibility for Crisis Services	1 – 5 5	The M-ACT team provides 24-hour response for crisis intervention services. The ACT on-call phone is rotated between M-ACT staff on a weekly basis. The team always maintains a primary and a secondary on-call responder. The M-ACT CC serves	

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			as the backup responder to all crisis calls and is available for consultation to on-call staff at any time.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The team was involved in the majority of hospitalize admissions. The reviewers experienced some inconsistency in the data provided for this item. In preparation for the review, data was requested for the ten most recent hospital admissions, but was only provided for four members. The team eventually provided data on seven of the last ten hospitalizations. The team was involved in the seven reported hospitalizations; most members were petitioned or amended for court-ordered treatment (COT); team involvement could not be confirmed for three of the ten most recent admissions. During the morning meeting observed, a weekly tracking of hospitalized members was reviewed; multiple members were inpatient due to medical or psychiatric concerns.	• Develop consistent tracking for all member hospitalizations.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The team was involved in the majority of hospital discharge plans. The reviewers experienced some inconsistency in the data provided for this item. In preparation for the review, data was requested for the ten most recent hospital discharges, but was only provided for two members. The team ultimately provided data on eight of the last ten hospitalizations; team involvement in discharge planning could not be confirmed for two of the ten recent discharges. The team was involved in the discharge planning and post-hospitalization follow up for all eight of the reported hospital discharges. The team adheres to a thirty-day follow-up schedule; it starts with an appointment with the Psychiatrist upon discharge, gradually adds contacts with other specialty staff over the thirty-	• Develop consistent tracking for all member discharges for enhanced continuity of care.

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			day period, and culminates with an assessment of status on the 30th day.	
O7	Time-unlimited Services	1 – 5 4	The team has graduated three members in the past 12 months and intends to graduate more than five percent of members in the upcoming year. The team uses a step-down process, working towards lessening the number of in-person contacts while preparing for transition to a lower level of care.	• Closely monitor closing criteria to ensure that arbitrary time limits are not imposed upon members. ACT services should be available to members for as long as they desire. • While this team is designated with a medical specialty, ensure that transition to a lower level of care is primarily reflective of their psychiatric stability and appropriateness for ACT services.
S1	Community-based Services	1 – 5 2	The results of the chart review show staff making contact with members in community settings approximately 32% of the time. The types of interactions that seemingly affected the data were the aggregate number of clinic-based contacts for members participating in medication observation and training. Member interviews concurred with the chart review findings; members often stated that they see staff up to five days-a-week in the clinic for these services. During morning meeting and some staff interviews there was also a focus on engaging members to attend various groups in the clinic, with plans to engage members at the new M-ACT team location to develop a variety of office-based groups.	• Revisit strategies for providing community-based care for members. ACT services are designed to be provided primarily in the community; support M-ACT staff to provide at least 80% of service time in the community. When skills are taught in their most naturally-occurring environment, they are better retained. Work with M-ACT team staff to brainstorm ideas to increase community-based services. • Other than substance abuse treatment groups which are likely to occur in the office, analyze the potential benefit of groups in the clinic versus providing those individualized supports to members in their communities. Supportive housing services, assisting with employment goals, peer support services, individual SA treatment, and other skill development activities should occur in the community rather than the clinic whenever possible.
S2	No Drop-out Policy	1 – 5 5	The team has retained more than 95% of their members in the past 12 months. The M-ACT CC	

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			reports that none of the members who left the team were discharged, dropped or moved without referral. Members who left the team were transferred for lack of qualifying insurance policies for PCP care, Arizona Long Term Care System (ALTCS), or graduated with significant improvement.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The M-ACT team uses an assortment of procedures to find members who have lost contact with the team. Staff described the use of a weekly contact approach, which is comprised of a checklist of sources that should be contacted while in search of the member (e.g., the morgue, representative payee). The team uses the contact strategy for six weeks prior to discussing the possibility of closing a member. Staff report that if a member makes contact with staff during that timeframe, the contact strategy is discontinued as services are resumed.	
S4	Intensity of Services	1 – 5 5	The team displays a high total amount of service time, frequently with interactions from multiple staff in the office setting. The record review indicates that members receive an average of 138.13 minutes of face-to-face contact per week. Though high service intensity is averaged throughout member records, individual charts indicated a sizeable variance in the allotment of time spent with members facing significant medical challenges and those with less persistent concerns. Members on the lowest end of intensity were receiving between 15 to 54 minutes per week, and members with higher intensity were receiving up to 267 minutes per week. Six of the members received an average of more than 120 minutes of service per week. Members also reported seeing staff less often, once they were	• Though the team operates within the medical specialty, the ACT principles should take precedence in service provision. Examine the current team strategy for the division of labor among staff for intensity of services (S4) and frequency of contact (S5), ensuring that all members regularly receive adequate attention and observation.

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			stabilized after a crisis (i.e. release from medication observation), and some report frequent staff contact in the office setting.	
S5	Frequency of Contact	1 – 5 5	The team displays a high frequency of service contacts with members. The record review indicated that members were being seen approximately four times a week on average, in-person, frequently by multiple staff in the office setting. Six of the ten members reviewed received an average of four or more face to face staff contacts per week; the other four members received, on average, less than three per week. Though the team shares responsibility for seeing all M-ACT members, it appeared that members with elevated levels of medical concern received notably more face-to-face interactions by team staff than those with more moderate medical needs. Records seem to suggest that those with moderate medical needs were receiving one to two contacts per week; this is less than half of the EBP recommended average. Meanwhile, those with more intense needs received nearly nine contacts weekly. Members interviewed also reported lower to moderate rates of face-to-face interaction with staff outside of the clinic, but frequent contact in the clinic for medication support services.	• See S1 and S4 for recommendations.
S6	Work with Support System	1 – 5 3	Staff and members report that the team seeks to involve supports that are actively engaged in member treatment. For example, the team PSS co-facilitates a weekly evening family group at another PIR clinic, where he has contacts with informal supports. The member record review indicates that M-ACT staff is in contact with support systems between two to three times per month on average. However, team contacts with	• Continue efforts to engage member support systems for sustained improvements in member functioning. • If a member declines to allow staff to make contact with informal supports this should be documented in the record. However, staff can generally receive information from informal supports and may be able to

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			informal supports ranged from zero to 15 during the month timeframe reviewed; there were zero contacts with informal supports for five of the ten members. Estimated average contact with informal supports across the team was difficult to determine during staff interviews. Data from one staff suggests for their individual caseload they have .5 contacts with informal supports, on average, per month. Data from the second staff suggests for their individual caseload they have three contacts with informal supports, on average, per month. Data from the CC suggests an average of less than 1.5 informal support contacts across all members on the team. Reviewers observed discussions among staff regarding their interactions with family members during the morning meeting, with a rough estimate of less than .5 contacts on average across the full team. It appears staff have less than two contacts per month, on average, for all members on the team.	share limited data with known supports in some situations. If necessary, review confidentiality guidelines when developing an agency plan to engage informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 3	The team does not provide regularly-scheduled, individualized co-occurring treatment to members at this time. Of the 39 members with a dual diagnosis, 20 of them receive some level of engagement from the SAS and other designated staff [CC and Clinical Director (CD)]. Staff acknowledge that treatment is focused on engagement and combined with the regular home visits. Reviewers noted that member charts echoed this pattern, with substance abuse interventions being documented by many different M-ACT staff. The CD is a LISAC, and currently provided one-on-one treatment to members when requested. Most often, the CD is available to provide direction and supervision to the SAS, rather than to provide direct,	• The agency should fill the vacant SAS position; ensure staff is trained and receives supervision to provide substance abuse treatment to the population served. • Continue efforts to engage members in treatment through the team. Substance abuse treatment should be dedicated and individualized, not just interventions during home visits, and should preferably follow a proven dual disorder model.

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			individualized substance abuse treatment.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 1	The team does not offer any ACT-specific co-occurring treatment groups to members at this time. Staff involved in the provision of co-occurring treatment services (SAS, CC, and Clinical Director) are receiving training from the provider agency on facilitating groups based in the Integrated Dual Diagnosis Treatment (IDDT) model. The agency is in the early implementation stage of an Integrated Dual Disorder Treatment Recovery Life Skills Program group curriculum. Staff intends to offer groups upon relocation to the new site. Members have been using community resources for group support in the interim.	• The team should prioritize the creation and regular offering of ACT-exclusive weekly groups focused on dual-diagnosis (DD) principles. • Provide training, supervision and guidance to SAS staff as the integrated dual diagnosis treatment recovery program is implemented; consider tracking member outcomes for members who participate in group once the new curriculum is implemented. • Start promoting the new group and explore engagement strategies that will encourage member attendance. (i.e.; open house, motivational interviewing, etc.); track member attendance via sign in sheets or other mechanisms.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The team regularly uses a stage-wise treatment model as the foundation for most member interventions. With respects to treatment models, the M-ACT staff were principally focused on the Trans-theoretical model (Stages of Change), including discussion of members' stages of change in the team morning meeting. Many staff described to reviewers how they are using the model to identify treatment options in all aspects of treatment planning. Staff often stated that harm reduction tactics were preferred interventions; however, there are occasions when detox is necessary beyond medical necessity. For example, some staff identified members that were sent by the M-ACT team to detox centers for methamphetamine use.	• Continue to educate staff on the principles of dual disorder treatment; constantly implementing the training and support needed to entrench its values into the team's culture.
S10	Role of Consumers	1 – 5	The Peer Support Specialist (PSS) provides direct	

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	on Treatment Team	5	services to members. The PSS is fully-integrated; he has a full caseload and is active in all aspects of member care. Staff report that the PSS is empathetic, has expertise in member engagement, therapeutic rapport and improving clinical outcomes. The PSS is also cross-trained in other ACT specialties and is effectively providing support in those areas (e.g. Substance Abuse).	
Total Score:		**4.04**		

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

7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
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	5
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.04**	
Highest Possible Score	**5**	