

## **ASSERTIVE COMMUNITY TREATMENT (ACT) FIDELITY REPORT**

Date: December 21, 2016

To: Crystal Domblisky-Klein, Director of ACT Services

From: Karen Voyer-Caravona, MA, LMSW  
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AHCCCS Fidelity Reviewers

### **Method**

On November 15 – 16, 2016, Karen Voyer-Caravona and Jeni Serrano completed a review of the Southwest Network Bethany Village 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.

Southwest Network (SWN) is contracted to provide behavioral health care to members diagnosed with a Serious Mental Illness (SMI) in Maricopa County. The Bethany Village Clinic is located at 4210 West Bethany Village Road, Phoenix, Arizona 85019, in Phoenix's Northwest Valley. The clinic is accessible by public transportation, and is in close proximity to local businesses. The Bethany Village ACT team serves 100 members. The team has historically served the SMI young adult population, and though no longer a young adult program, the team still serves significant numbers of young adult members.

The individuals served through the agency are referred to as "members" so that term will be used in this report.

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

- Observation of a daily ACT team meeting;
- Individual interview with Team Leader/Clinical Coordinator (CC);
- Individual interviews with a Substance Abuse Specialist (SAS), the Rehabilitation Specialist (RS), and the Peer Support Specialist (PSS).
- Group interview with two members receiving services;
- Charts were reviewed for ten members record using the agency's electronic medical records system; and
- Review of agency/team documents: the CC's encounter log; resumes for the two SASs, the RS, and the Employment Specialist; the Regional Behavioral Health Authority (RBHA) ACT Admission Screening Tool; and the member roster notes for the team meeting.

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

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

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

### **Summary & Key Recommendations**

The agency demonstrated strengths in the following program areas:

- The ACT team includes two Nurses who are 100% dedicated to the team and have no outside responsibilities to distract from member needs. Both conduct home visits to deliver medication and provide injections but also to respond with case management functions that meet members' immediate needs and concerns.
- The ACT team has two Substance Abuse Specialists with the training, experience, and motivation to provide members with both individual and group substance abuse treatment, as well as cross-train other specialists.
- The ACT Peer Support Specialist is a full member of the team with equal duties and responsibilities of the other specialists. Other specialists recognize the PSS's lived experience as a necessary resource and support for members' recovery, and the PSS uses disclosure to inspire and motivate members to create and work toward their own recovery vision.

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

- The agency needs to hire a permanent full-time Psychiatrist whose time is 100% dedicated to providing care to all ACT members.
- The agency and the RBHA should ensure that all specialists have the training, mentoring and clinical oversight to become fully responsible for all services, eliminating the need to refer to outside providers.
- The ACT team should focus on delivering individualized services in the community and avoid over-reliance on group activities not specifically required for the evidence-based practice of ACT. For example, consider which group activities would be more appropriately provided by peer-run agencies and which activities may offer more member benefit if delivered individually, potentially increasing fidelity in both Intensity of Services (S4) and Frequency of Contact (S5).
- The agency should encourage and support the two qualified SASs to provide individual and group substance abuse treatment to all members on the team who are diagnosed with a co-occurring disorder (COD). Also, the SASs should provide ongoing cross-training to other specialists in the COD model to increase COD member engagement in those services.

**ACT FIDELITY SCALE**

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The Bethany Village ACT team serves 100 members. The member to staff ratio is 11:1. The staff roster consists of nine direct service staff, excluding the Psychiatrist: (1) Clinical Coordinator, (2) Registered Nurses, (2) Substance Abuse Specialists, (1) Employment Specialist, (1) Rehabilitation Specialist, (1) Independent Living Specialist, and (1) ACT Specialist. A new Housing Specialist had been hired to join the team but had not yet started at the time of the review, so he (or she) was not included in this calculation.	
H2	Team Approach	1 – 5 3	Per staff and member interviews, all staff are responsible for seeing all members. Coverage is organized by regions, which rotate weekly by staff. Staff interviewed said regional coverage is flexible so that staff can see members outside their assigned regions. If they are in a different region they can see members in that area to ensure contacts or respond to members' immediate needs. A review of ten randomly selected member records found members had contact with multiple specialists 60% of the time in a two week period, which was within the range estimated by the Clinical Coordinator (CC).	<ul style="list-style-type: none"> <li>• Ensure multiple staff contacts with members at least 90% of the time in a two week period. Identify and find solutions to factors that contribute to members not having contact with multiple specialists.</li> </ul>
H3	Program Meeting	1 – 5 5	The ACT team holds a daily program meeting Monday through Friday. The Monday meeting is condensed to primarily update the team on member needs, such as crisis that arose over the weekend, so not all members are discussed. All members are reviewed during the Tuesday – Thursday meetings. The CC said that the team rotates reviewing the member roster to either start at the beginning or the end of the alphabet, to ensure equal discussion is given to each	

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			member throughout the week.	
H4	Practicing ACT Leader	1 – 5 3	The CC estimated that he spends 60% - 70% of his time providing direct member services, primarily in the community. The CC facilitates a bi-weekly bowling group for two hours that he reports is well-attended. The records reviewed also found that the CC attends staffings with members and conducts home visits to perform needs assessments and medication observation. Per the CC's productivity report provided to the reviewers, over a 30 day period the CC spent 23% of this time providing direct member services.	<ul style="list-style-type: none"> <li>The team supervisor should provide services at least 50% of the time.</li> <li>Consistently document face-to-face encounters with members in the agency's documentation system.</li> <li>Identify any administrative task currently performed by the CC that could be provided by other staff, such as the Program Assistant. This could free his time to provide more direct service.</li> </ul>
H5	Continuity of Staffing	1 – 5 3	In the 24 months preceding the review period, the ACT team lost 12 staff members for a turnover rate of 50%. The position of Housing Specialist turned over three times. The Nurse position turned over twice. The ACT team has lost two Psychiatrists in the last 24 months, and the service is currently being filled by three covering agency Psychiatrists..	<ul style="list-style-type: none"> <li>In an attempt to decrease staff turnover to no more than 20% in two years, identify factors that may contribute to staff turnover, as well as those that support retentions. If not already in use, consider conducting period staff satisfaction survey and exit interviews.</li> </ul>
H6	Staff Capacity	1 – 5 3	The ACT team operated at a staffing capacity level of 78% for the 12 months preceding the review. The positions of Nurse, Substance Abuse Specialist (SAS), and ACT Specialist (AS) were the most difficult to fill.	<ul style="list-style-type: none"> <li>See recommendations for Item H5, Continuity of Staffing.</li> </ul>
H7	Psychiatrist on Team	1 – 5 2	At the time of the review, the ACT team had been without a full-time, permanent Psychiatrist since October 21, 2016. Three agency Psychiatrists provide rotating coverage at the clinic on Mondays, Wednesdays, and Fridays until a permanent Psychiatrist is hired. On Mondays, an agency Psychiatrist sees members over telemedicine services, and also sees non ACT members who come to the clinic. The two other Psychiatrists cover Wednesday and Friday and are	<ul style="list-style-type: none"> <li>Hire a full-time Psychiatrist whose time is 100% dedicated to providing care to ACT members.</li> </ul>

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			responsible for ACT members at clinics where they are assigned full-time. Staff reported that all three Psychiatrists attend morning meetings on their respective days of coverage. None are currently doing home visits. The ACT team does not have Psychiatric coverage on Tuesdays and Thursdays. The CC reported that staff can contact the Psychiatrist over email or phone, and that the Nurses also assist in contacting them with questions and concern.	
H8	Nurse on Team	1 – 5 5	The ACT team has two full-time Nurses who are 100% dedicated to the team. Neither have responsibilities outside the ACT team. Both provide nursing services at the clinic and during home visits. In addition to coordinating medical services with primary care providers (PCP), preparing medi sets, conducting hospital visits, delivering injections, and refilling prescriptions, the Nurses both provide case management services in response to members' immediate needs. Evidence of this was found by reviewers multiple times in the record review. The Nurses have offices in the same area as the rest of the ACT team, attend the daily program meeting, and are described by staff interviewed as highly accessible in person, by email and by phone. Both work four, ten hour days with either Monday or Friday off.	
H9	Substance Abuse Specialist on Team	1 – 5 5	Two experienced and trained Substance Abuse Specialists serve the ACT team and its 53 members diagnosed with a co-occurring disorder (COD). SAS1 has been with the ACT team since February 2015; she has a Master's degree in the Science of Addiction Counseling and is credentialed as a Licensed Associate Substance Abuse Counselor (LASAC). Previous to employment on the ACT	

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			team she worked with a variety of populations with addictions, eating disorders, and co-occurring illnesses at a residential treatment center. SAS2 joined the ACT team in October 2016, has five years previous experience on another ACT team, and is Spanish-English bilingual. In addition to her professional experience in substance abuse treatment, her resume disclosed her lived experience of addictions recovery and experience as a 12-step sponsor.	
H10	Vocational Specialist on Team	1 – 5 4	The ACT team has two vocational staff, a Rehabilitation Specialist (RS) and an Employment Specialist (ES). The RS has been in the position for two years and received quarterly training from the agency and the RBHA, including DB101 and in the administration of the Vocational Activities Profile. The ES joined the team in late October 2016. Her resume provided to the reviewers indicates that previous to the team, the ES worked for seven months as a Case Manager with one of the agency's supportive teams. Prior to that position, she worked in higher education financial aid offices with duties that included assisting students with finding employment.	<ul style="list-style-type: none"> <li>Ensure that the ES is provided training and mentoring specifically related to assisting ACT members in obtaining and retaining employment in integrated work settings.</li> </ul>
H11	Program Size	1 – 5 5	When fully staffed, the ACT team consists of 12 staff. At the time of the review, the ACT team was of sufficient size and diversity to provide for the needs of its 100 members, with ten full-time direct service staff. At time of review, the team had two vacancies; one vacancy was reported to have been filled and scheduled to start the week after review and the Psychiatrist position has temporary coverage while pending hire. The agency was seeking a full-time permanent Psychiatrist.	
O1	Explicit Admission	1 – 5	The ACT team follows clearly defined admission	

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	Criteria	5	criteria as outlined in the RBHA ACT Admission Screening Tool. The CC said that since the team was previously reserved for young adults it continues to receive many transitional age youth/young adults, although age is not a criteria. Referrals come from MMIC, other clinical teams and programs that service young adults, if they meet SMI designation. The CC does most of the screening but the SAS1 may also conduct them. The CC will meet the person, go through the screening tool, and offer services if appropriate. If the person is interested, he or she will be invited to meet with the team. The ACT Psychiatrist makes the final decision on admission. The CC said that the team maintains a waiting list, so they have little need to recruit members.	
O2	Intake Rate	1 – 5 5	The ACT team has admitted ten members in the last six months: (1) May, (3) June, (0) July, (0) August, (2) September, and (4) October. At the time of the review the CC said that they have one individual to screen for the team, and if admitted, the person will move to the waiting list.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The ACT team is fully responsible for all psychiatric services: three agency Psychiatrists rotate coverage for all members, and two Nurses see members in both the clinic and out in the community. The ACT team is also fully responsible for providing housing services, including assistance with finding and retaining housing. According to the daily staff roster, five members live in settings that provide staff supports: 24-hour residential (3), 16-hour residential (1), and a developmental disability home (1). The agency does not refer for supportive housing services. The agency is fully responsible for providing substance abuse treatment, including co-occurring groups and	<ul style="list-style-type: none"> <li>Continue efforts to empower the ACT Specialist (AS), who is licensed to provided counseling/psychotherapy, to engage members who would benefit in those services. Consider ways to educate referral sources and guardians/caregivers on the benefits of having the ACT team provide counseling/psychotherapy.</li> <li>The ACT team, especially the RS and the ES, should receive training on the ACT team's role in assisting members in finding and retaining employment in integrated work settings. All ACT staff should be able to</li> </ul>

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			<p>individual substance abuse treatment, and does not refer out for those services.</p> <p>Short staffing over the previous review periods may have limited the ACT team's ability to provide services offered in two areas -- individual counseling/psychotherapy and vocational services. Staff interviewed said that six members see outside providers for counseling/psychotherapy. The new ACT Specialist is licensed to provide individual counseling/psychotherapy but at the time of the review had only just started to accept referrals. Staff interviewed gave varying accounts of whether or not members are referred to outside providers for employment services; some said no members used outside providers, while other said some members received pre-employment training and piece work assignments from two outside providers. No evidence in interviews, the program meeting, or records reviews showed that the ACT team was actively working with any members on employment goals.</p>	<p>provide some level of support in finding and retaining employment, including support at the job site so as to avoid the use of outside employment providers.</p>
O4	Responsibility for Crisis Services	1 – 5 4	<p>The ACT team provides daily 24 hour crisis services. The on-call schedule rotates weekly and begins from 6 p.m. to 7 a.m. The CC is the back up, and members have the on-call number, as well as a list of all specialist cell phone numbers The program assistance fields calls during the day directly to team specialists. Reflected in the score is that some Psychiatrist notes referred members to call 911 or the Crisis Line in the event of an emergency.</p>	<ul style="list-style-type: none"> <li>Ensure that the Psychiatrist(s) understand and articulate to members the ACT team's role in providing crisis services, especially after hours services.</li> </ul>
O5	Responsibility for Hospital Admissions	1 – 5 4	<p>A review of the last ten psychiatrist hospital admissions found that the ACT team was involved in 70%. Two were admitted by family members who did not notify the ACT team prior to</p>	<ul style="list-style-type: none"> <li>Continue to educate members and their informal supports on the benefits of contacting ACT staff during crisis and when</li> </ul>



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			admission, and one member self admitted. Staff interviewed said that while the team encourages families to contact them first when they think members need to be hospitalized, family members often focus on the immediate crisis. Staff also said that homeless members sometimes use the hospital as a source of shelter.	considering the need for a psychiatric hospitalization.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	A review of the last ten psychiatric hospitalizations showed that the ACT team was directly involved in 100% of discharges. Discharge planning, which included staffings with hospital social workers and conversations between the hospital and ACT Psychiatrists, begins at the time of admissions or as soon as the ACT teams learns about the hospitalization. ACT staff visit members while they are inpatient; pick the member up at discharge; transport them to where they are living, ensure that the member has medications, groceries, and basic necessities; and ensures that they see the team Psychiatrist within three days. ACT staff conduct five-day follow up, seeing the member at their residence or at the clinic to monitor the member for safety and stability.	
O7	Time-unlimited Services	1 – 5 5	The ACT team provides time unlimited services to members. Two members graduated with significant improvement in the last year. Two members are expected to graduate in the next several weeks, with perhaps two more graduating in the next 12 months. In recommending a step down to the supportive level of care, the team considers such factors as medication compliance and knowledge, the level and quality of community involvement, the member’s informal support network, and 90 – 120 days of stable housing and employment. Either the team or the member may introduce the idea of stepping down.	

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			The difference in the level of service is carefully explained to the member, and the decision is up to the member. Graduations are celebrated with the member, who is free to return to the ACT team if desired.	
S1	Community-based Services	1 – 5 2	Staff interviewed estimated that 80% of member contacts occur in the community, stating they provide community group outings such as trips to the mall, bi-weekly bowling outings, and a recent member luau party. Records reviewed found that community-based contact occurred 32% of the time, and individual community contacts consisted primarily of medication observations and brief assessments of the home environment.	<ul style="list-style-type: none"> <li>Continue to explore and implement a contact strategy that will reduce the amount of time spent meeting members in the office.</li> <li>Focus community contacts on individualized services that promote skill building, the development of natural support, self-advocacy, and connection with services and community resources.</li> </ul>
S2	No Drop-out Policy	1 – 5 5	The ACT team retained 99% of its caseload over the previous 12 month period. One person left the geographic area without notice, after numerous team efforts to provide housing. Another member was on outreach but had been located in jail and was refusing visits from the team.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT staff interviewed reported that they are not in a rush to close members who are out of contact with the team, stating that as an ACT team it is their responsibility to outreach members and continue efforts to engage with no listed timeframe of closure. Although no written outreach/engagement strategy was provided to the reviewers, staff described a four-week outreach protocol for reengaging members who have been out of contact with the team. Outreach activities includes phone calls, texts, and letters; follow up with payees, guardians, probation officers, and informal supports; visiting last known addresses, shelters, and frequent known locations; and calls to jail, hospitals and morgues. If those	<ul style="list-style-type: none"> <li>Consider developing a written outreach policy outlining specific tasks for a six to eight week timeframe.</li> </ul>

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			efforts do not yield results, the closure process is initiated, but cases are not closed without the team first determining they have exhausted efforts to locate the member.	
S4	Intensity of Services	1 – 5 3	As per a review of ten randomly selected member records, members received an average of 54.6 minutes of face-to-face contact with staff each week. Some staff interviewed described previous low staffing level/turnover as a barrier to the quality of contacts with members.	<ul style="list-style-type: none"> <li>The ACT team should provide members an average of two hours of face-to-face contact each week. Intensity may vary based on the member's stage of recovery, but an average of two hours across the team should be the goal. Contacts should be person-centered, based on needs, and delivered in the community to best promote skill building and new knowledge (see recommendation for item S1, Community-based Services).</li> </ul>
S5	Frequency of Contact	1 – 5 3	As per the record review, members received an average of 2.13 contacts with staff per week. Staff reported that shortage of staff and staff turnover contributed to lower frequency of contacts between staff and members.	<ul style="list-style-type: none"> <li>The ACT team should provide members with an average of four contacts per week. Contacts should be purposeful, person-centered, and recovery oriented (see recommendations for items S1, Community-based Services, and S4, Intensity of Services).</li> </ul>
S6	Work with Support System	1 – 5 3	Staff interviewed reported that at least 85% of members have informal supports, usually family members. Per the record review, ACT specialists had contact with .70 informal member supports each week. In the observed program meeting, the reviewers heard staff discuss recent contacts with member supports. The score reflects this combined data.	<ul style="list-style-type: none"> <li>Continue efforts engage member informal supports as partners in members' recovery.</li> <li>Periodically review with members the benefits of allowing staff to initiate contact with informal supports, and obtain signed release of information forms (ROI) whenever possible.</li> <li>Ensure that all contacts between informal support and staff are documented in the member record.</li> </ul>
S7	Individualized	1 – 5	The SAS1 is licensed to provide individual	<ul style="list-style-type: none"> <li>SAS should provide an average of at least</li> </ul>

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	Substance Abuse Treatment	3	<p>substance abuse treatment and was identified as responsible for that task. Of the 49 members identified with a co-occurring disorder, it was reported to the reviewers that 27 of them are seen by the SAS1 at least once a month; approximately five are seen weekly, and ten are seen every other week. Per report, all are seen for an average of 30 minutes but the sessions may last up to 90 minutes. Members are usually seen at their home. Members are not formally scheduled but given a timeframe upon which to expect the SAS1 to arrive and are aware that substance abuse will be the topic of conversation. The reviewers heard the SAS1 discuss efforts to engage with COD members in individual substance abuse counseling. While the reviewers found evidence of the SAS1 conducting home visits with members diagnosed with a co-occurring disorder in the record review, they did not find documentation of individualized substance abuse treatment.</p>	<p>24 minutes weekly of individual substance abuse treatment across all members diagnosed with a COD. Sessions should be scheduled, and not an adjunct to a standard home visits. Meetings should be formally structured and preferably use a stage-wise treatment approach that align with the member’s stage of change. The EBP of ACT does not require that individualized substance abuse treatment be performed by a licensed clinician, but SASs should be given the necessary clinical oversight to allow for this service to be provided on the team.</p> <ul style="list-style-type: none"> <li>• Ensure that individualized substance abuse treatment is documented as such.</li> </ul>
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	<p>The ACT team provides members with one co-occurring disorders treatment group each Monday from 2:00 – 3:00 p.m. Staff reported using the Integrated Dual Diagnosis Treatment approach incorporating rational emotive/cognitive behavioral techniques, stage wise interventions, psychoeducation, and harm reduction. Staff reported the group follows a curriculum provided by the provider agency, SAMHSA resources, and some materials created by the SAS1. The group is attended by ACT members only, and approximately 16 -17 members (34%) attend at least one co-occurring group a month. The reviewers found evidence of members attending substance abuse groups in the record review with topic such as relapse prevention and managing</p>	<ul style="list-style-type: none"> <li>• Continue outreach and engagement efforts to increase substance abuse group participation to 50% of ACT members diagnosed with a COD.</li> <li>• With the start of a second SAS consider adding substance abuse groups to increase opportunities for those COD diagnosed members who have not yet engaged in substance abuse treatment services.</li> </ul>

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			holiday triggers to avoid relapse.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Per staff interviews the ACT team appears to have moved in the direction of primarily using the co-occurring model. The SAS1 demonstrated a depth of understanding of the stage-wise treatment approach and was able to describe using interventions that align specifically with different stages of change. Likewise, it was reported to the reviewers that the SASs are providing regular training to the other specialists in substance abuse. While some staff may be more familiar and ground in the 12-step recovery model, the culture of the team was described as shifting from a traditional abstinence orientation to one of supporting reduced and/or less lethal use of substances (harm reduction). Staff are encouraged to process with members the pros and cons of substance use and to have discussions with the Psychiatrist and Nurses about how illicit substances could interact with psychiatric medication or affect psychiatric symptoms. Per the record review, reviewers saw documentation of staff offering and encouraging members to join the substance abuse groups.	<ul style="list-style-type: none"> <li>The agency and the RBHA should continue efforts to train and support all ACT specialists in the co-occurring model. Increasing staff retention and hiring a full-time Psychiatrist may expedite the ACT team becoming fully based in the co-occurring model.</li> </ul>
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has a Peer Support Specialist who is recognized by staff and members not only as a person with lived experience but also as a full member of the team with responsibilities equal to those of other specialists. The PSS was previously employed in the same position on another ACT team, and he views himself as an example of what can happen in recovery through the building of skills and using services.	
<b>Total Score:</b>		<b>3.93</b>		

**ACT FIDELITY SCALE SCORE SHEET**

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	2
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	4
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	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	3
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	5
<b>Total Score</b>		<b>3.93</b>
<b>Highest Possible Score</b>		<b>5</b>