ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

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To: Dan Ranieri, Chief Executive Officer

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Introduction

Arizona Health Care Cost Containment System has contracted with the Western Interstate Commission for Higher Education Behavioral Health Program to conduct fidelity reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is Evidence-Based Practice (EBP).

Method

On August 4 – 6, 2025, Fidelity Specialists completed a review of the **La Frontera- Empact Capitol Center** ACT team. This review is intended to provide specific feedback for the development of your agency's ACT services in an effort to improve the overall quality of behavioral health services in Maricopa County.

La Frontera-Empact provides crisis and behavioral health services to adults, children, and families. This agency operates three ACT teams in Maricopa County. For the purposes of this report, the focus will be on the Capitol Center ACT Team. The individuals served through the program are referred to as *clients*, but for the purpose of this report and for consistency across fidelity reports, the term *member* will be used.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely using videoconferencing and telephone to observe meetings and to interview staff and members.

During the fidelity review, reviewers participated in the following activities:

- Remote observation of an ACT team program meeting on August 5, 2025.
- Individual videoconference interview with the Clinical Coordinator (CC).

- Individual videoconference interviews with Housing, Rehabilitation, Employment, Independent Living Skills, and Peer Support Specialists, as well as one Co-Occurring Disorders Specialist, who also serves as the licensed counselor for the team.
- Individual phone interviews with three (3) members participating in ACT services with the team.
- Closeout discussion with the CC, Serious Mental Illness (SMI) ACT Program Manager, and representatives from the Arizona Health Care Cost Containment System (AHCCCS) and the contractor with a Regional Behavioral Health Agreement (RBHA).
- Charts were reviewed for 10 randomly selected members using the agency's electronic health records system. The sample included members from the following health plans: RBHA and Other (Medicare, private, or other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; *8 Week Outreach form*; *Mercy Care ACT Manual;* copies of cover pages of substance use disorder treatment materials utilized (SAMHSA's *Integrated Treatment of Co-Occurring Disorders* toolkit, Living in Balance Core Program by Hazelden, and *Substance Abuse Treatment and the Stages of Change)*; co-occurring disorders treatment group sign-in sheets; resumes and training records for both the Vocational and Co-Occurring Disorders Specialist staff; ACT Team Brochure; productivity report for the CC for a recent 30-day period, staff region assignment calendar, and a member region list.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It determines the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries, and the Nature of Services. The scale has 28 program-specific items, and each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented with little room for improvement*).

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

Summary and Key Recommendations

The agency demonstrated strengths in the following program areas:

- Practicing ACT Leader: Since the previous review (July 17, 2023), the team significantly improved and is closer to fidelity in this area. The CC provides direct services to members approximately 38% of the time expected of other ACT specialists. ACT leaders that have direct clinical contact are better able to model appropriate clinical interventions and remain in touch with the members served by the team.
- Continuity of Staffing: The team experienced a turnover rate of 13% in the last two years. Maintaining a consistent staff enhances team cohesion and the therapeutic relationships between members and staff. It also preserves the historical experiences of the members.
- Staff Capacity: In the past 12 months, the team has operated at approximately 97% of its full staffing capacity. The timely filling of vacant positions also helps to reduce the potential burden on staff.

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

- Responsibility for Hospital Admissions: The team was directly involved in 40% of the 10 most recent member psychiatric hospital admissions. ACT teams performing to high fidelity of the model are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission.
- Work with Informal Support System: Records reviewed showed an average of 0.60 contacts with natural supports over a 30-day period. Ensure consistent documentation of attempted contact with natural supports occurs, including by phone, email, text messages, and in-person.
- Co-Occurring Disorders Treatment Groups: A review of sign-in sheets showed that approximately 25 (32%) unique members attended at least one co-occurring disorders treatment group in a month period. Optimally, 50% or more of members with a substance use disorder should attend at least one co-occurring disorders treatment group each month.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team currently serves 98 members and includes 11 full-time equivalent (FTE) direct service staff. This excludes the psychiatric prescriber and administrative staff. The team has a member-to-staff ratio of 9:1. The direct service staff consists of the CC, two Registered Nurses (RN), two Co-Occurring Disorders Specialists (CODS), one Rehabilitation Specialist, one Employment Specialist, one Housing Specialist, one Independent Living Skills Specialist, one ACT Specialist, and one Peer Support Specialist (PSS).	
H2	Team Approach	1 – 5 5	Staff reported that approximately 85–90% of members interact with more than one ACT staff during a two-week period. Excluding the CC, the team follows a 4-day, 10-hour shift schedule, with two specialists scheduled on weekends to support member engagement and continuity of care. Caseload responsibilities are shared across the team. Staff oversee approximately 10 members in order to manage administrative tasks such as updating service plans and assessments. The team utilizes a zoned approach with daily regional assignments to ensure members have the opportunity to interact with all staff. Members interviewed reported interacting with one to three staff each week.	

			Of the 10 randomly selected member records reviewed, 100% received in-person contact from more than one staff in a two-week period.	
H3	Program Meeting	1 – 5 5	Per interviews, the team meets in person four days per week and reviews all members at each meeting. All staff attend meetings on scheduled workdays. Reports were inconsistent about the purpose of the Wednesday meeting—some indicated it is fully dedicated to reviewing all members, while others stated it is used for co-occurring disorders or other clinical training. During the program meeting observed, staff discussed recent engagement efforts and planned outreach activities for each member. Topics included member treatment engagement, stage of change, medication management, group attendance, medical provider coordination, housing related issues, and support for members that were hospitalized or incarcerated. The Program Assistant read member names, and the CC and psychiatric prescriber provided guidance to staff relating to the prioritization of service delivery to address member needs.	
H4	Practicing ACT Leader	1 – 5 4	The CC has been in the role for over two years and estimated providing approximately 40 hours of in-person services to members per month. In the 10 member records reviewed, the CC was documented conducting home visits with members to assess for needs, providing education on harm reduction, identifying treatment goals, and providing independent living skills training. The CC also facilitated co-occurring disorders groups in the office.	• Continue efforts to provide in-person services to members 50% or more of the expected productivity of other ACT staff.

			The productivity expectation for in-person service delivery for team staff is 105 hours per month. A productivity report for a recent 30-day period showed the CC delivered 39.9 hours of direct service, resulting in approximately 38% of the expected productivity for ACT staff. *This item is dependent on the Provider productivity expectation.*	
H5	Continuity of Staffing	1 – 5 5	Based on information provided and reviewed with staff, the team experienced a turnover of 13% during the past two years. The positions affected by turnover during this period were the RN, CODS, and PSS roles, with one staff vacating each role.	
H6	Staff Capacity	1 – 5 5	In the past 12 months, the team has operated at approximately 97% of full staffing capacity. During this period, the RN and CODS positions were vacant for two months, and the PSS role was vacant for one month.	
H7	Psychiatrist on Team	1 – 5 5	The team includes a dedicated Medical Doctor who serves as the psychiatric prescriber and works exclusively with members of this ACT team. Staff reported the psychiatric prescriber primarily provides services in person at the clinic, with community visits one day per week. Staff and members reported that psychiatric appointments occur every 2-4 weeks. The psychiatric prescriber coordinates care with inpatient and referring providers, educates ACT staff, prescribes medications, assesses and diagnoses members, and provides treatment recommendations. Staff can reach the psychiatric prescriber via cell phone, messaging application, email, or in person.	

			Of the 10 records reviewed, nine included documented psychiatric prescriber appointments, and one reflected ongoing outreach efforts to engage a member. Two psychiatric prescriber appointments were conducted via videoconference.	
H8	Nurse on Team	1 – 5 5	The team is staffed with two full-time RNs that support the caseload of 98 members. Responsibilities include administering injections, providing medication education and training, conducting home and hospital visits, and delivering medications. The RNs also draw labs, perform Health Risk Assessments, and coordinate care with primary care physicians. Staff can reach the RNs via cell phone, messaging application, email, or in person.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	The team includes two Co-Occurring Disorder Specialists (CODS). One CODS is a Licensed Professional Counselor (LPC) and Licensed Independent Addiction Counselor (LIAC) with several years of substance use treatment experience and recent relevant training. The second CODS has been in the role since February 2025 with no prior relevant experience. Training documents provided show 2.5 hours of training related to substance use or co-occurring disorders. This CODS does not receive formal, regularly scheduled clinical supervision from a qualified professional specific to substance use treatment.	• Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach* and the evidence-based practice of *harm reduction*. The CODS support the team by cross-training staff and guiding interventions based on members' stage of change and the team's adopted co-occurring disorders model. • Ensure Co-Occurring Disorders Specialist staff are provided with regular supervision from a qualified professional to support delivery of individual and group substance use treatment services in an integrated treatment model approach.

H10	Vocational Specialist on Team	1 – 5 4	The team includes one Employment Specialist and one Rehabilitation Specialist. Resumes for both reflect more than one year of relevant experience in supporting members with obtaining and maintaining employment in integrated work settings. Both specialists had one hour of recent vocational-related training.	• Provide ongoing training, guidance, and supervision to Vocational Specialist staff, including at least four (4) hours of annual training focused on employment and vocational support services. Training should emphasize best practices that help members obtain competitive jobs in integrated settings.
H11	Program Size	1 – 5 5	At the time of the review, the team was comprised of 12 FTE staff, including the psychiatric prescriber. The team was of sufficient size to adequately provide services to members and had no vacant positions.	
O1	Explicit Admission Criteria	1 – 5 5	Per interviews, the team follows the *Mercy Care ACT Admission Criteria* to screen potential members. Staff stated that eligible individuals must have an SMI designation and an independent living skills goal. Additionally, it was reported that all members admitted must have co-occurring disorders (substance use disorder diagnosis). Referrals are typically submitted internally or by external providers such as local hospitals and outpatient clinics. The CC and psychiatric prescriber conduct the initial admission screening. The psychiatric prescriber completes a doctor-to-doctor consultation with the referring prescriber. Cases are then presented to the ACT team and staffed collectively. If the team is in agreement and the member agrees to services, staff schedule the intake or assume care if the member is hospitalized. Staff reported not feeling pressured to admit members that do not meet ACT criteria.	

O2	Intake Rate	1 – 5 5	Based on data provided and reviewed with staff, the team has an appropriate rate of admission. The team has accepted a total of six new members during the past six months, with no more than three admissions monthly.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric services and medication management, counseling/psychotherapy, substance use treatment, and employment/rehabilitative services. Per the information provided and reviewed with staff, 12 members (approximately 12%) reside in staffed settings where service duplication occurs, including Flex Care, behavioral health residential facilities, and residential treatment centers.	*In the evidence-based practice of ACT, all member services are delivered by the ACT team. As a transdisciplinary service delivery model, area specialists are trained and cross trained to provide the core components of ACT: case management, psychiatric services, counseling/psychotherapy, employment and rehabilitation services, housing support, and substance use treatment.* • ACT teams assist members to find housing in the least restrictive environments, which can reduce the possibility for services overlapping with other housing providers. • Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff providing housing support. Enlist natural supports as a resource to assist in identifying housing options and providing support.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour crisis support using a rotating on-call schedule, with one staff member assigned daily. The licensed CODS, psychiatric prescriber, and RNs are excluded from the rotation; the CC serves as backup to support staff. Crisis support is provided via phone or in-person, based on member need. Staff assess for danger to self or others and other urgent concerns, first attempting de-escalation by phone before responding in the community.	

			When hospitalization is warranted, staff coordinate care by initiating petitions for court-ordered evaluation or providing transport when it is safe to do so. Members interviewed confirmed access to staff outside of regular business hours, including evenings and weekends. Two of the three members interviewed were unaware of the on-call number and reported contacting staff directly after hours.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported the team is actively involved in psychiatric hospital admissions. During crises, staff assess member needs and when safe, transport members to the clinic for immediate evaluation by the psychiatric prescriber or RNs. When hospitalization is deemed necessary, staff are involved throughout the admission process by providing or arranging transportation and coordinating with hospitals and emergency responders. Per a review of data with staff relating to the 10 most recent psychiatric hospital admissions which occurred over a five-month time frame, the team was directly involved in 40%. For admissions not coordinated by ACT staff, members self-admitted to hospitals. Staff became involved after being notified by the hospital or natural supports.	• ACT teams performing to high fidelity of the model are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. • Develop hospitalization plans with members in advance, especially when they have a history of hospitalization without seeking team support.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that discharge planning begins at the time of hospital admission. The psychiatric prescriber conducts staffings with the inpatient provider, and ACT staff coordinate care through the hospital stay, including visiting members	

			while hospitalized. The team participates in inpatient staffings approximately every three days and collaborates with guardians and natural supports when appropriate. Discharge planning activities include reviewing treatment options, ensuring medication coordination, and linking members to services such as residential treatment, substance use programs, and in-home supports. At discharge, staff provide transportation, support retrieval of prescribed medications, ensure the member has food at home, and assist with tasks such as picking up checks. Following discharge, the team implements a five-day follow-up protocol which includes daily in-person or phone contact with a specialist, a psychiatric prescriber and RN appointment within 72 hours, and a scheduled primary care appointment. Hospital discharge planning was discussed during the program meeting observed. Based on a review of data with staff relating to the 10 most recent psychiatric hospital discharges which occurred over a four-month period, staff were directly involved in 100%.	
O7	Time-unlimited Services	1 – 5 5	Data provided showed no members graduated from the team with significant improvement in the past 12 months. Staff reported five members are anticipated to graduate in the next 12 months.	

S1	Community-based Services	1 – 5 4	Staff interviewed reported that 70-80% of in-person contacts with members occur in the community. Results of 10 randomly selected member records reviewed showed staff provided services a median of 79% of the time in the community. Records indicated the psychiatric prescriber attempted at least one home visit in the last 30 days. RNs documented providing home visits for medication delivery, observation, and education; administration of injections; and assistance scheduling primary care physician appointments. Additionally, records showed staff completing home visits to provide independent living skills training, conducting brief mental status exams, and discussing harm reduction techniques. Two members reported seeing staff in the community on a weekly basis. One member reported receiving home visits from staff once a month.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1 – 5 5	According to data reviewed with staff, four members dropped out of the program in the past year. The team retained approximately 96% of the total number of members served in the past 12 months. When a member no longer requires the intensity of ACT services, staff discuss stepping the member down. If the member requests to step down, the team will review progress over the last 12 months for hospitalizations or crisis calls. If the member has remained stable and is meeting	

			their goals, the team will modify the service plan and reduce the frequency of home visits to facilitate the transition.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff reported using multiple assertive engagement strategies to retain and re-engage members, including phone calls, coordination with probation or parole officers, and visits to homeless shelters, last known addresses, hospitals, and jails. Other efforts involve checking locations frequented by the member, contacting natural supports, and checking with payees and guardians. During the program meeting observed, the team discussed outreach plans for disengaged members, identifying staff responsible for follow-up, coordination of care, and possible next steps. Reviewers were provided with the *Mercy Care ACT Manual* outlining assertive engagement protocols, along with an *8 Week Outreach* form. While records included some documentation to support outreach efforts, staff provided inconsistent descriptions regarding the duration of outreach activities. Records reviewed showed lapses in engagement in 60% of records ranging from 5 to 7 days, with no documented outreach attempts. One record showed that a member missed a psychiatric prescriber appointment, and no outreach was documented. Shortly afterward, the member called crisis and was subsequently hospitalized.	

S4	Intensity of Services	1 – 5 4	Per a review of 10 randomly selected member records during a month period before the fidelity review, the median amount of time the team spends in-person with members per week was approximately 111 minutes. The average weekly intensity ranged from 72 – 305 minutes. The median duration for alternative methods of contact such as phone was 2.50 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• Evaluate how the team can engage with or enhance support for members that receive a lower intensity of service. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly.
S5	Frequency of Contact	1 – 5 4	Of the 10 randomly sampled records, ACT staff provided a median frequency of 3.13 in-person contacts to members per week. Sixty percent (60%) of records reviewed indicated multiple same-day contacts for several members. For example, one member attended a clinic appointment and then had additional contacts with multiple staff on the same day. Among the records reviewed, the highest frequency of weekly in-person contacts was 9.25, while the lowest was 2.25. Phone contact was documented in four records, and two records indicated the team conducted videoconference visits for members in staffed placements.	• Increase the frequency of contact with members by ACT staff, optimally averaging four (4) or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have diverse needs/goals, and frequency of contact should be determined by those needs and immediacy.
S6	Work with Support System	1 – 5 3	Data provided identified 49 members (50%) with natural supports. Staff reported contacting natural supports weekly and documenting the contacts in electronic member records. During the program meeting observed, staff identified these natural supports for approximately 32 members and reported	• Assist members in developing a natural, community-based support system. Active participation with peer-run programs is a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural

			contact if it occurred. Contact was noted while conducting home visits, phone calls, in attendance of psychiatric appointments, and in hospital staffings. One interviewed member stated that the team engages with their supports on an as-needed basis. Another member reported contact by the team with their supports occurs approximately once per month. Records reviewed showed an average of 0.60 contacts with natural supports over a 30-day period. Two records documented staff interaction with a member's natural supports.	supports with whom they have lost contact. • Ensure consistent documentation of attempted contact with natural supports occurs, including contact by phone, email, text messages, and in-person.
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	At the time of the review, 78 members were identified with co-occurring disorders. Staff estimated that 29 (37%) of these members participate in weekly structured individual substance use treatment with the CODS staff. Specialists reported holding weekly or bi-weekly sessions with members which are primarily in person. Of the 10 records reviewed, nine (90%) identified members with co-occurring disorders. Eight of these records included contact with a CODS, however, documentation did not reflect discussion specific to co-occurring disorders treatment. Encounters typically ranged from 30 to 70 minutes. Based on member calendars provided, 23 members received individual substance use treatment sessions during a recent month.	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders. • Explore training on strategies to engage members in substance use treatment. On ACT teams, all staff engage members with co-occurring disorders to participate in individualized treatment based on their stage of change, with content reflecting stage-wise treatment approaches.

			Session frequency ranged from two to four sessions per month with an average of approximately 17 minutes per member per week of individualized substance use treatment.	
S8	Co-Occurring Disorders Treatment Groups	1 – 5 3	The team offers four in-person substance use treatment groups weekly at the office that are facilitated by one of the CODS and the CC. Staff interviewed reported that 25-35 members with co-occurring disorders attend at least one group per month. Member records reviewed showed three of the nine members receiving group substance use treatment. A review of sign-in sheets showed that approximately 25 (32%) unique members attended at least one group in a month period. Reviewers were provided with the following reference materials utilized to direct group sessions: SAMHSA's *Integrated Treatment of Co-Occurring Disorders Toolkit* and two manuals that are not in alignment with the co-occurring disorders treatment model.	• Optimally, 50% or more of members with a substance use disorder attend at least one co-occurring disorders treatment group each month. • Ensure COD group topics and manuals referenced consistently reflect evidence-based substance use treatment principles, rather than general mental health recovery strategies.
S9	Co-Occurring Disorders Model	1 – 5 4	The team broadly endorses an Integrated Treatment for Co-Occurring Disorders model for members with substance use disorders. During the observed program meeting and in records reviewed, staff frequently referenced members' stage of change and stage of treatment, working to engage individuals where they are in their recovery process. While the team embraces a harm-reduction philosophy, some staff identified abstinence as a preferred long-term goal.	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as *Integrated Co-Occurring Disorders Treatment*, in the principles of a *stage-wise approach* to interventions, the EBP of *harm reduction,* and *motivational interviewing.* • Provide training to staff on how interventions are more effective when they align with a member's stage of change, i.e., a stage-wise approach. Stage-

			Staff described utilizing practical harm-reduction strategies, including supporting transitions to less harmful substances and working with members to reduce overall use. Motivational interviewing techniques are also applied, including setting substance use-related goals and supporting members to work toward meeting them. The team encourages participation in both individual and group treatment to promote recovery. Members may be referred to detoxification programs for use of alcohol, benzodiazepines, or opiates. One program meeting each week (Wednesday) is utilized for clinical instruction or occasionally co-occurring disorders training. Most staff indicated primary training on co-occurring disorders comes from Relias modules assigned by the agency. Of the nine records reviewed for members with co-occurring disorders, seven included treatment plans with identified substance use goals. Several plans and progress notes referenced "IDDT" as the focus of contact. Some individual session and group notes lacked detail about the interventions provided or the information shared during the contact. Records frequently used traditional language such as "sobriety" and "relapse".	wise treatment and matching interventions are an essential element of the *Integrated Co-Occurring Disorders Treatment* model.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team includes at least one staff with lived or living psychiatric experience and when appropriate shares their personal recovery journey with members.	

			The three interviewed members were aware of peer staff on the team. Members shared that staff with lived experience were a valuable addition to the team, as the presence of peers on the team made members feel more understood and supported.	
Total Score:		**124**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score
1. Small Caseload	1 - 5	5
2. Team Approach	1 - 5	5
3. Program Meeting	1 - 5	5
4. Practicing ACT Leader	1 - 5	4
5. Continuity of Staffing	1 - 5	5
6. Staff Capacity	1 - 5	5
7. Psychiatrist on Team	1 - 5	5
8. Nurse on Team	1 - 5	5
9. Co-Occurring Disorders Specialist on Team	1 - 5	3
10. Vocational Specialist on Team	1 - 5	4
11. Program Size	1 - 5	5
Organizational Boundaries	Rating Range	Score
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	3

6. Responsibility for Hospital Discharge Planning	1 - 5	5
7. Time-unlimited Services	1 - 5	5
Nature of Services	Rating Range	Score
1. Community-Based Services	1 - 5	4
2. No Drop-out Policy	1 - 5	5
3. Assertive Engagement Mechanisms	1 - 5	5
4. Intensity of Service	1 - 5	4
5. Frequency of Contact	1 - 5	4
6. Work with Support System	1 - 5	3
7. Individualized Co-Occurring Disorders Treatment	1 - 5	4
8. Co-occurring Disorders Treatment Groups	1 - 5	3
9. Co-occurring Disorders Model	1 - 5	4
10. Role of Consumers on Treatment Team	1 - 5	5
Total Score	**4.43**	
Highest Possible Score	**5**	