ASSERTIVE COMMUNITY TREATMENT
FIDELITY REVIEW REPORT

Date: August 8, 2025

To: Amy B. Henning, President & Chief Executive Officer
Crystal Domblisky-Klein, Senior Director of Integrated Health and Population Management

From: Madison Chamberlain, BS
Melissa Porphir, MS
AHCCCS Fidelity Specialists

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 an Evidence-Based Practice (EBP).

Method

On July 14 – 16, 2025, Fidelity Specialists completed a review of the **Southwest Network Northern Star** ACT team. This review is intended to provide specific feedback on 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 operates three ACT teams out of Arizona. The Northern Star site has a primary care provider that supports the entire agency in delivering integrated care. The individuals served through the program are referred to as *members*.

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 July 15, 2025.
- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with Co-Occurring Disorders, Housing, Rehabilitation, Independent Living, and Peer Support Specialists for the team.

- Individual phone interviews with four members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, Senior Director of Integrated Health and Population Management, and representatives from AHCCCS and the contractor with a Regional Behavioral Health Agreement.
- 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: contractor with a Regional Behavioral Health Agreement and American Indian Health Plan.
- Review of documents: *Mercy Care ACT Admission Criteria*; *Southwest Network Lack of Contact Checklist* form; on-call number and individual staff contact information flyer; monthly group calendar; copies of cover pages of substance use disorder treatment materials utilized; co-occurring disorders treatment group sign-in sheets; and resumes and training records for Vocational and Co-Occurring Disorders Specialist staff.

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. The scale determines 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 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:

- Small Caseload: The team has an appropriate member to staff ratio of 10:1 and serves 95 members.
- Program Meeting: The team meets four days per week to discuss all members assigned to the team. The Psychiatrist attends three days a week.
- Practicing Team Lead: This item has improved since the last review. The Clinical Coordinator provides direct services to members 54% of the time expected of other ACT specialists.
- Psychiatrist on Team: The team has one fully dedicated Psychiatrist that is readily available to the team and provides services to members in the office and in their community.
- Nurse on Team: The team has two fully dedicated Nurses that serve the ACT members. Services are provided in the office and in the community.
- Time-unlimited Services, No Dropout Policy: The team provides time-unlimited services and has a low dropout rate, retaining 99% of members.

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

- Vocational Specialist on Team: Continue efforts to have at least two full-time Vocational Specialists and provide at least four (4) hours of annual training focused on employment and vocational support services to ensure implementation of best practices in supporting members obtaining and maintaining competitive jobs in integrated settings.
- Intensity of Services: Increase intensity of services to average two (2) or more hours of in-person services a week to provide individualized services and improve outcomes for members.
- Frequency of Services: Increase the intensity and frequency of services to average four (4) or more in-person contacts a week. On ACT teams, all staff are invested in high frequency and individualized services for members.
- Work with Support System: Increase contacts with natural supports to an average of four (4) contacts per month for each member with a support system. ACT teams have frequent inclusion and interactions with natural supports to support building a recovery network for members.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 95 members with 10 full-time equivalent (FTE) direct care staff, excluding the Psychiatrist assigned to the team or agency primary care providers. The team has an appropriate member to staff ratio of 10:1. The team is comprised of the following staff: Clinical Coordinator, two Registered Nurses (Nurses), two Co-Occurring Disorders Specialists (CODS), Rehabilitation Specialist, Peer Support Specialist, Housing Specialist, Independent Living Specialist, and ACT Specialist.	
H2	Team Approach	1 – 5 3	Staff report that nearly 100% of members are seen by more than one staff in a typical two-week period. Staff reported utilizing a zoned approach, in which staff are assigned different geographic regions daily to ensure coverage. At the end of the program meeting observed by reviewers, staff reported which geographic area and members would be contacted for the day. Staff reported having assigned caseloads to ensure that members have updated assessments and service plans. Staff reported that staff are primarily responsible for ensuring contact with members on caseload but will also see members off caseload. Of the 10 randomly selected member records reviewed, 60% received in-person contact from more than one staff from the team in a two-week period.	• In the EBP of ACT, 90% of members have in-person contact with more than one staff in a two-week period. • Eliminate caseload assignment. ACT teams are designed with high-needs members in mind. The entire caseload should be shared across ACT team staff. Diversity of staff interaction allows members access to unique perspectives and expertise of staff, as well as the potential to reduce burden of responsibility of member care on staff.

H3	Program Meeting	1 – 5 5	The team meets four days a week to discuss every member on the roster. The Psychiatrist attends these meetings three days a week. The meetings are held in person and occasionally staff will call into the meeting via video conference when in the community. During the observed program meeting, the Clinical Coordinator led the discussion by calling out member names and giving clinical guidance, including identifying members requiring additional follow-up for appointments or outreach. Staff reported on recent interactions with members, upcoming appointments, the members' current stages of change, and current coping skills or strengths of the member. The Psychiatrist joined virtually part way through the meeting.	
H4	Practicing ACT Leader	1 – 5 5	Staff reported the Clinical Coordinator provides direct, in-person services to members, which accounts for approximately 50 - 60% of the team productivity expectations. Staff reported that the Clinical Coordinator outreaches and engages with members that tend to be the most difficult to locate. For these members, the Clinical Coordinator conducts street outreach and visits locations members frequent often. The Clinical Coordinator also completes medication observations, independent living and vocational skills training with members, and meets with members in-person after psychiatric hospitalization. Based on the hospitalization data provided and reviewed with staff, the Clinical Coordinator	

			transported one member to the hospital for admission and was directly involved in transporting members for four hospital discharges. Per the 10 member records reviewed, there was evidence within 20% of the records of the Clinical Coordinator providing in-person services to members. Team staff have a minimum expectation of 22 hours of direct in-person services per week. The monthly productivity report received showed the Clinical Coordinator provides direct services to members 54% of the time expected of other ACT specialists. *This item is dependent on the Provider productivity expectation.*	
H5	Continuity of Staffing	1 – 5 4	Based on information provided and reviewed with staff, the team experienced a turnover rate of approximately 21% during the past two years. Five staff left the team in the past two years, and the position with the highest turnover was the Employment Specialist with two staff leaving the team.	• If not done so already, attempt to identify factors that contributed to staff turnover or that support retention. Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their natural supports, as well as reducing the potential burden on staff.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the team has operated at approximately 92% of full staffing capacity. The Employment Specialist position has been vacant for seven months and has been vacant the longest.	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually. • Support specialty staff to work in their area of interest and expertise with members. Research shows staff remain in positions longer when supported in their roles by being provided supervision and training in their specialty practice.

H7	Psychiatrist on Team	1 – 5 5	The team has one full-time Psychiatrist that serves only ACT members. The Psychiatrist is responsible for prescribing psychiatric medications, coordinating care with outside providers, and providing guidance to staff regarding the decision to hospitalize members, among other responsibilities. The Psychiatrist works four days a week and is available to the team after the clinic business hours. Staff can reach the Psychiatrist via messaging applications, phone, or email. Staff reported that members meet with the Psychiatrist in-person or through videoconferencing in the clinic or in the member's community. All four members interviewed reported meeting with the Psychiatrist once a month typically in the clinic. One member reported seeing the Psychiatrist two times a month on occasion.	
H8	Nurse on Team	1 – 5 5	The two full-time Nurses only serve ACT members and work 10 hours four days a week and have staggered schedules to ensure coverage on the team. Both Nurses attend all four program meetings. Staff reported that the Nurses will see members at the clinic or in the community. The Nurses coordinate with specialists and primary care providers, provide medication education, perform vitals, and coordinate with pharmacies to meet members' medication needs. Staff reported that the Nurses are accessible during business hours by phone, and messaging applications. The Nurses are not available after-	

			hours or on the weekends, so staff consult the Psychiatrist for emergencies outside of business hours.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 4	The team includes two CODS, and both have at least one year of substance use treatment experience. One CODS is a Certified Recovery Specialist per the resume provided. Per the provided training records, one CODS completed at least four hours of substance use treatment training, while the other completed 1.25 hours within the past 12 months. Per the training records and staff interviews, the CODS along with other staff on the team, receive weekly clinical oversight facilitated by the Psychiatrist.	• Provide eight (8) hours of annual training to CODS 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 treatment and the team's adopted co-occurring disorders model. • Ensure CODS 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 2	At the time of the review, the team included one full-time Rehabilitation Specialist and had a vacancy for the Employment Specialist. The Rehabilitation Specialist has been with the team since 2017 with many years of experience providing vocational services to individuals with serious mental illnesses. Per the training records provided, the Rehabilitation Specialist completed one hour of annual training in *Supported Employment: Individual Placement and Supports* within the past 12 months.	• 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. • ACT teams maintain two full-time Vocational Specialist staff with at least one year of experience providing employment support.
H11	Program Size	1 – 5	The team is comprised of 11 FTE direct service staff including the Psychiatrist. At the time of the	

		5	review, the Employment Specialist position was the only vacancy on the team.	
O1	Explicit Admission Criteria	1 – 5 5	Reviewers were provided with the *Mercy Care ACT Admission Criteria* tool that staff reported utilizing to screen potential ACT members. Staff reported receiving referrals from the contractor with a Regional Behavioral Health Agreement, internally from the agency/clinic, outside providers, and guardians. Staff reported there is no pressure to admit members that do not meet ACT criteria. Upon receiving the referral, the Clinical Coordinator conducts a screening with the member and explains the nature of ACT services. If the member meets criteria, then the Clinical Coordinator meets with the team and Psychiatrist to decide whether ACT services are appropriate. The Psychiatrist has the final say if the member is admitted to the team. The Psychiatrist will then coordinate with the referring provider to discuss the member. Staff reported that ACT is voluntary, and when the member is offered services, the member chooses ultimately to accept or decline ACT.	
O2	Intake Rate	1 – 5 5	Per the data provided and reviewed with staff, the member admission rate was appropriate with the highest rate of admission being two admits in June 2025.	

O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides the majority, over 90%, of the following services to ACT members: Psychiatric services and medication management, housing support, substance use treatment, and employment/rehabilitative services. Counseling/psychotherapy services are not provided by the ACT team. Staff reported that approximately 5% of members receive counseling and are referred to a counselor within the agency.	*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.* • Consider exploring options to provide counseling services to members of the ACT team, either through new or currently existing ACT staff.
O4	Responsibility for Crisis Services	1 – 5 5	The team is responsible for providing crisis services to members 24 hours per day, seven days a week. All staff excluding the Nurses on the team rotate on-call responsibilities weekly. The Clinical Coordinator and Psychiatrist are available on-call after hours and on weekends. Members are provided with the on-call phone number and individual staff contact information on a flyer when joining the team. Additional copies are available to members when requested. When members are in crisis and utilize the on-call number after hours, ACT staff will provide support over the phone, meet members in the community when appropriate to further assess the situation, and transport members to the hospital when necessary. All four members interviewed identified after hours support from the team as a resource	

			during urgent situations outside of business hours.	
O5	Responsibility for Hospital Admissions	1 – 5 4	When members experience crises during business hours, staff will transport the member to the clinic to meet with the Psychiatrist for evaluation to ultimately decide whether the member requires hospital admission. For voluntary hospital admissions, staff will transport members to the hospital and sit with the members through intake. For involuntary hospitalizations or when there are safety concerns, staff will initiate the petition or amendment process. Staff will contact first responders, such as police, and will meet at the member's location to coordinate care and explain the member's situation. Staff reported following first responder transportation to the hospital to provide pertinent details to inpatient staff. Per review of data with staff relating to the 10 most recent psychiatric hospital admissions over a four-month period, the team was directly involved in 80%. For the hospital admissions in which the team was not directly involved, one member self-admitted two times to the hospital without informing the team.	• ACT teams performing to high fidelity of the model are directly involved in 95% or more of psychiatric admissions. • For members that frequently admit without involving the team, consider revisions to member treatment plans to address behaviors and/or circumstances related to self-admissions.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	When members are admitted to hospitals, staff reported conducting visits in-person with members while hospitalized, providing medication lists to inpatient staff, coordination of care between the Psychiatrist and hospital providers, and coordination for discharge with the member and hospital.	

			When members discharge from the hospital, staff reported following a five-day follow-up protocol. Staff will transport the member from the hospital to the member's residence. The member is scheduled with the Psychiatrist within 72 hours of discharge. Staff will visit the member in-person every day for five days and are scheduled to meet with the Psychiatrist weekly for five weeks. Per the review of data with staff relating to the last 10 psychiatric hospital discharges over a four-month period, the team was directly involved in 100%.	
O7	Time-unlimited Services	1 – 5 5	Based on the data provided and reviewed with staff, the team had no members graduate with significant improvement in the past 12 months. At the time of review, no members were expected to graduate within the next 12 months. Staff reported collaborating with the member, natural supports, and Psychiatrist when gauging whether members are ready to begin stepping down services and eventually graduate.	
S1	Community-based Services	1 – 5 3	Staff reported 70 - 85% of in-person contacts with members occur in the community. Results of 10 randomly selected member records reviewed show staff provided services a median of approximately 59% of the time in the community. Community-based services included transporting members, accompanying members to doctor appointments, grocery shopping, medication deliveries, and substance use	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. • For members that come into the clinic multiple times a week, explore how to deliver those services in community settings.

			treatment counseling and groups in the community.	
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had one member that dropped out of the program in the past year due to staff being unable to locate the member after outreach attempts. The team has retained 99% of the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The *Southwest Network Lack of Contact Checklist* form was provided to reviewers, which details the outreach protocol when members are not engaging in services. Staff reported outreach to members includes the following: Calling members' phone; conducting home visits; checking hospitals, jails, and morgues; driving to locations members are known to frequent; and contacting guardians, advocates, natural supports, and payees. To engage members in services, staff reported facilitating several different groups that help members get out of the house and socialize with others. Groups offered by the team include grocery shopping, coping skills, men's support, substance use treatment including an art-based recovery option, and a monthly family support group. Of the 10 member records reviewed, there were four records in which members had no documented outreach for 10 days or greater. The highest number of days with no	• When members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Discuss and track these efforts during the program meeting. • Consider peer review of documentation to ensure efforts are accurately included in member records.

			documented outreach was 13 days for two members.	
S4	Intensity of Services	1 – 5 2	Per a review of 10 randomly selected member records during a month period prior to the fidelity review, the median amount of time the team spent in-person with members per week was approximately 48 minutes. The highest weekly average direct service time was approximately 203 minutes, and the lowest was approximately 12 minutes. The median weekly time spent for services provided by phone was 1.75 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. Ensure services are accurately documented. • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. Documented service time is significantly higher for some members than for others. Provide individualized support to members, including those that elect not to participate in groups.
S5	Frequency of Contact	1 – 5 2	Of the 10 randomly sampled records, ACT staff provided a median frequency of 1.50 in-person contacts to members per week. The highest average weekly in-person contact was 5.50 and the lowest was one in-person contact per week. The median frequency of weekly phone contact was 0.63 times per week.	• Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. • Ensure staff are trained and supported in using appropriate documentation standards to ensure that services delivered are appropriately reflected in medical records in a timely manner.
S6	Work with Support System	1 – 5 2	Per the data provided and reviewed with staff, approximately 75% of members (71) have identified natural supports. Staff reported having contact with approximately 30 – 50% of natural supports in the past 30 days. Staff reported	• Increase contacts with natural supports to an average of four (4) per month for each member with a support system. As much as possible, contact natural supports

			contact with natural supports varies between every two to four weeks. Staff will contact member natural supports in emergencies, to re-engage members, or to coordinate care for members. Per staff interviews and the group calendar provided, the ACT team offers monthly support groups to natural supports. In the observed program meeting, staff identified known natural supports of members and reported recent contact with approximately 21% of member's natural supports. One member reported recent contact between staff and natural supports during home visits. Three members reported staff only speaking with natural supports in emergency situations. Of the 10 member records reviewed, seven members were identified with natural supports, with a monthly average of 0.30 contacts with natural supports. Of these members, two records had documentation of contact with natural supports.	during the natural course of delivery of services provided to members. • Assist members in developing a natural, community-based support system. Continue to encourage members to actively participate with peer-run programs and provide assistance in members reengaging with natural supports with whom they have lost contact.
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	Per the data provided and reviewed with staff, approximately 74% of members (70) have identified co-occurring disorders, excluding those diagnosed with caffeine or nicotine addictions. Approximately 43% (30) are currently engaged in structured, individual substance use counseling. Staff reported utilizing the stages of change and motivational interviewing to guide individualized treatment. Staff reported pulling	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with co-occurring disorders. • Utilize curriculum and materials which have been shown to be effective for members with co-occurring disorders, e.g., mental illness and substance use disorders. Seek guidance from the larger

			materials from the SAMHSA website and utilizing a stages-of-change group substance-use treatment curriculum to inform individual member's substance use treatment. Staff reported that each CODS will schedule approximately 15 members weekly for individual co-occurring disorder treatment. Sessions are typically 30 minutes, and staff reported each CODS utilizing separate member appointment tracking mechanisms (e.g., online calendars and paper tracking). Of the nine records identified with co-occurring disorders, four members had documentation of one individual substance use counseling in a 30-day period. These sessions ranged from 18 – 45 minutes in length.	agency or health plan for support to identify appropriate models and approaches that are effective for this high-risk population. • Monitor and track member engagement and participation in individual substance use treatment service delivery by the ACT team.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 3	Per the group calendar provided and interviews, the CODS provide three weekly co-occurring disorders treatment groups, including one that incorporates art into the recovery curriculum. Two of the groups are offered in the community, one in a park, weather permitting, and the other within an unstaffed halfway/recovery home where eight members reside. Reviewers were provided a copy of the curriculum used for the co-occurring disorders treatment groups, which was specific to stages-of-change group treatment for substance use and did not incorporate mental illness, i.e., integrated treatment of co-occurring disorders. Per the group sign-in sheets provided, approximately 31% of members with co-	• Co-occurring disorder treatment groups work best when based in an evidence-based practice (EBP) treatment model specific to those with serious mental illnesses. Consider structuring groups around proven curriculum for optimal impact for this high-risk population. • Continue to engage members with co-occurring disorders to participate in group substance use treatment, as appropriate, based on their stage of change. Ideally, 50% or more of applicable members participate in co-occurring disorders group monthly.

			occurring disorders attended at least one co-occurring treatment group in the last month.	
S9	Co-Occurring Disorders Model	1 – 5 4	All staff interviewed were familiar with the stage-wise approach and reported utilizing harm reduction strategies over abstinence expectations. Staff reported that the main treatment model used for treating members with co-occurring disorders is Integrated Dual Diagnosis Treatment or currently referred to as Integrated Treatment for Co-Occurring Disorders. The team provides information for traditional substance use treatment groups (e.g., *Alcoholics Anonymous*) if requested by the member. Members are referred to detoxification programs for opiates or alcohol. Per review of the nine records of members with identified co-occurring disorders, six treatment plans had substance-use specific treatment goals. Five treatment plans identified harm reduction goals and strategies (e.g., goal for a member to reduce using a substance from three times a week to once a week). Four of the six treatment plans identified goals with traditional language.	• 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 and the EBP of *harm reduction,* and *motivational interviewing.* • Use a client-centered approach to ensure members' expressed goals are documented in service plans, minimizing clinical jargon. Model positive recovery-focused language for those members citing rigid expectations of abstinence.
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff identified at least one member on the team with lived or living psychiatric experience, including certified peer support staff. Staff reported that consumer staff have the same responsibilities as others, share stories of recovery with members, and advocate from the peer perspective.	

			All members interviewed reported knowledge of staff on the team that have lived or living psychiatric experience. Two members shared that having a peer on the team is valuable, as it helps staff relate more effectively to members and to better understand what members are experiencing.	
Total Score:		**114**		

ACT FIDELITY SCALE SCORE SHEET

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

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	3
2. No Drop-out Policy	1 - 5	5
3. Assertive Engagement Mechanisms	1 - 5	4
4. Intensity of Service	1 - 5	2
5. Frequency of Contact	1 - 5	2
6. Work with Support System	1 - 5	2
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	**4.07**	
Highest Possible Score	**5**	