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

Date: August, 28 2015

To: Derrick Baker, Clinical Coordinator

From: Jeni Serrano, BS
T.J Eggsware, BSW, MA, LAC
ADHS Fidelity Reviewers

**Method**

On August 5-6, 2015 Jeni Serrano and T.J Eggsware (Fidelity Reviewers) completed a review of the Lifewell Behavioral Wellness' South Central 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.

Although the team has been functioning for more than two years, the team and site transitioned to a different provider. The change in provider, from Choices to Lifewell Behavioral Wellness, occurred August 1, 2015. Lifewell Behavioral Wellness supports include outpatient counseling, community living, vocational rehabilitation, residential, transportation, and housing.

The individuals served through the agency are referred to as clients or participants, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

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

- Observation of a daily ACT team meeting
- Individual interview with Clinical Coordinator (i.e., Team Leader)
- Group interview with 5 members receiving services through the ACT team
- Individual interview with a member receiving services through the ACT team, assisted by a Spanish translator
- Individual interviews with Substance Abuse Specialist (SAS), Housing Specialist (HS) and Rehabilitation Specialist (RS)
- Charts were reviewed for ten members using the agency's electronic medical records system
- Review of ACT team admission criteria, and *ACT Team Substance Abuse Group Workbook* created by the Regional Behavioral Health Authority (RBHA)

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:

- Staff-to-member ratio and team size is within identified fidelity standards
- There is evidence of a team approach based on member interview, records reviewed, staff report and observation of AM meeting.
- During the AM meeting, multiple staff appeared to be aware of member statuses and shared their experiences working with members; these interactions were often linked to the specific staff specialties.
- The team has two SAS staff with at least one-year training and experience, it is reported the team uses motivational interviewing with evidence some staff are familiar with a stage-wise treatment approach.

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

- Due to a high level of staff turnover, if not in place, the agency should consider using staff satisfaction surveys to determine factors contributing to staff retention, as well as staff exit interviews/surveys to determine what contributes to staff turnover. Review options to improve technology that allows ACT staff to be more productive in the community (e.g., smartphones, functioning laptops with wireless internet accessibility).
- SAS staff do not provide individual SA counseling; staff report the SAS staff are not licensed. The SAMHSA ACT model does not require licensure or specific certification as a requisite for staff to provide SA treatment; training and experience are the focus. The team, network, RBHA, and ADHS should explore if ACT staff In Arizona are allowed to provide individual substance abuse treatment directly or under the supervision of qualified staff.
- The agency needs to evaluate administrative duties and activities of the CC in order to increase community direct service percentage. It is recommended that the CC increase direct service time to at least 50% of the time.
- The team needs to increase their efforts to involve members' identified support system. It is recommended that the team support and encourage members to identify their informal supports (i.e., people not paid to support members, such as family, landlord, neighbor, friend) and then assist them in acquiring the knowledge, resources and skills needed to support members.
- The team should increase the intensity and duration of services to members, including community-based activities. Services should be delivered primarily in the community and not the office setting; the team should identify what services are currently delivered in the clinic setting that can be provided to members in the community. Consider revising the clinic policy of having staff in the clinic the last two hours of each shift allowing the ACT team staff more flexibility to provide community-based services.

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| H1 | Small Caseload | 1 – 5 (5) | This team has ten staff and a roster of 100 members, so the member to staff ratio for this team is 10:1. This count excludes the psychiatrist and the administrative support staff. | |
| H2 | Team Approach | 1 – 5 (5) | ACT members are being served by multiple staff, in-person, 90% of the time based on records reviewed. Most of the members interviewed report contact with multiple staff. Staff who conduct medication observation meet regularly with members who receive the support, but they also rotate contact with other members. All staff are appointed to work in assigned zones and continue to rotate monthly in order to assure that all staff gets to know all members and their needs.<br><br>During AM meeting observation there was evidence of a team approach; on more than one occasion a staff would update the status of services provided to a member, then identify another staff who would provide additional information and summarized their contact, plan, etc. for the member. These contacts were often based on engagement activities affiliated with specific ACT specialties (i.e. substance abuse intervention, housing services, etc.) | |
| H3 | Program Meeting | 1 – 5 (5) | The team meets four days a week for the daily morning meeting, with a shorter meeting on Thursday due to the Psychiatrist field activities that occur on that day. The expectation is that all staff on the team must attend on days scheduled to work. The Psychiatrist and the Nurse attend the full morning meetings three out of the four days due to their flex schedules. The morning meeting is organized in a checklist format addressing need, | |

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| | | | concerns and updates rather than by alphabetic order of roster. All members on this team are discussed four days a week, even if only briefly. | |
| H4 | Practicing ACT Leader | 1 – 5 (2) | The CC estimates he spends about 30% of his time providing direct member services. He added that he met with his Clinical Director to discuss the reassignment of administrative duties and tasks to other staff on the team, with the intention of increasing direct services to members, including making recent efforts to complete home visits. However, the CC notes the recent transition to a new provider increased his administrative duties, and decreased his time for direct member services. An activity log was requested for a specified period, and, apparently due in part to the provider transition, only a screen shot of total billed minutes was provided; the report reflected an average of 16.44 hours per week. However, the report appears to reflect all types of documented activities; not only face-to-face contacts, but coordination with others without the members present. Additionally, based on documentation reviewed, actual service minutes tend to be less than billed time, with services less than 15 minutes rounded up to that amount, so the total billed hours of 65.75 is not an accurate reflection of actual direct services provided to members.<br><br>Ten records were reviewed and CC provided a total of 29 minutes of direct services to those tem members over a month period, about 1% of all documented direct services, and no contact was over ten minutes in duration. Based on available information, it appears the CC provides direct face-to-face member services on rare occasions as backup, with some brief member contacts in the | • The CC should continue to work with clinic and agency leadership to determine if all identified administrative functions are required. CC responsibilities may be an area of further review to determine if action should occur at a system level. The need for this level of intervention cannot be fully confirmed at this time.<br>• CC needs to increase direct services to 50% in order to remain in touch with the members served by the team and model appropriate clinical interventions.<br>• The CC should implement a tracking system to ensure all direct service time is captured and reported accurately. |

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| | | | clinic. | |
| H5 | Continuity of Staffing | 1 – 5 (2) | The team experienced 71% turnover in 2 years with a total of 17 staff leaving positions. There was a transition of staff on the team that included: a new Clinical Coordinator as of April, 2015, loss of the established team Nurse around the time a second team Nurse was hired in May, 2015 (in order to fulfill two Nurses for the team), two different Locum Tenens (LT) covering the team when no permanent Psychiatrist was assigned, and the recent loss of two staff as the clinic transitioned from Choices to Lifewell. | • While the team has managed to fulfill criteria for the program size (item H11), the lack of critical positions (i.e. second Nurse, Peer Support Specialist) may affect quality of services and potential member outcomes. If not in place, the agency should consider using staff satisfaction surveys to determine what is working to retain staff as well as staff exit interviews/surveys to determine what contributes to staff turnover. |
| H6 | Staff Capacity | 1 – 5 (4) | The team operated at 91% of full staffing in the past 12 months. | • See comments above for H5. |
| H7 | Psychiatrist on Team | 1 – 5 (5) | The Psychiatrist assigned to the team was hired full time 100% on June 29, 2015. The Psychiatrist's flex work schedule is four, ten-hour days, Tuesday through Friday. He is not the lead Psychiatrist and therefore has no additional supervision responsibilities. Staff interviewed report that he is assigned to only this team and is accessible; however, on occasion he is required to see other members (e.g., some members under Court Ordered Treatment) at the clinic because he is the only Psychiatrist onsite at this time. Per report, the Psychiatrist spends one half-day per week in the field making contact with members, rotating weeks between visiting members in hospital settings, visits to supervisory care homes, and home visits. | |
| H8 | Nurse on Team | 1 – 5 (3) | The team currently has one full-time Nurse assigned to the 100 members of the team. The Clinical Coordinator reported during the interview that the team recently had two Nurses for a short time, but their lead Nurse resigned shortly after the second Nurse was hired. Clinical Coordinator reported that | • Determine options for obtaining an additional Nurse. Nurses function as full members of the team and serve as educators to both members and staff. Two Nurses will ensure flexibility and availability of medical services such as injections and |

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| | | | he values the Nurse's flexibility, accessibility, willingness to go out in the community and ability to provide education and support in team meetings. Clinical Coordinator stated that he hopes the open position is filled soon because he knows the team would greatly benefit from an additional Nurse; a team with two Nurses could manage the responsibilities of medication observation and administration for members, as well as provide more community contacts and education to members on the team. | labs in the community and at the clinic. |
| H9 | Substance Abuse Specialist on Team | 1 – 5 (5) | The two Substance Abuse Specialists on the team remain the same as last year's review. Both SAS' have previous case management experience and additional experience in adolescent treatment, inpatient psychiatric care and as an Emergency Medical Technician (EMT). Both SAS staff are self-identified as peers in recovery for substance abuse. SAS interviewed was able to articulate the basic principles of harm reduction, stages of change and states the team continues to use motivational interviewing techniques to encourage engagement and harm reduction. | |
| H10 | Vocational Specialist on Team | 1 – 5 (2) | This score has decreased this review due to staff turnover. The team currently has both positions of Employment Specialist (ES) and RS filled. The Clinical Coordinator reported that the new ES hired on 3/16/2015 does not have any training/ experience in vocational rehabilitation and support other than what he has received from Choices or the RBHA quarterly meetings. The RS has been in her role for about a year-and-a-half and reports her role is primarily to engage members in developing and accessing community activities; this includes taking members on program tours and facilitating socialization with others. | • Fully integrated ACT teams include vocational services to assist members to find and keep jobs in integrated work settings. The team should identify potential barriers to directly providing vocational services versus referring to outside providers.<br>• Review training and supervision options to ensure staff identified in the role of Vocational Specialists (i.e., ES and RS) receive support, monitoring, and education in the specific vocational role for the |

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| | | | | population served (i.e., adults diagnosed with a serious mental illness). |
| H11 | Program Size | 1 – 5 (5) | The team currently has ten staff including the Psychiatrist (excluding administrative support staff). Current team vacancies are the Peer Support Specialist (PSS), and Transportation Specialist (TS). | |
| O1 | Explicit Admission Criteria | 1 – 5 (5) | CC provided reviewers with a copy of the written criteria set by the RBHA and reports that he continues to conduct the screenings with members who have been referred, then discusses them with the team, and states that the Psychiatrist has the final decision on whether the member is accepted to the ACT team. The CC reports that while he has been the CC of the team, he has not experienced any administrative pressure to accept members that the staff does not feel are appropriate for the team. | |
| O2 | Intake Rate | 1 – 5 (5) | Clinical Coordinator reported that there were only 12 admissions on the ACT team in the last six months. The team accepted three in the month of January, four in the month of March and five in the month of June. | |
| O3 | Full Responsibility for Treatment Services | 1 – 5 (3) | The Clinical Coordinator and staff interviewed reported that besides case management, the team directly provides psychiatric services and housing supports. CC and staff report that the team RS and ES do provide engagement, some interest assessment, tours of programs and some light job development support such as resume writing, internet searches and job fairs. However, some members need more support and the team sends referrals to employment support providers, including some members with a co-located agency or other work adjustment training (WAT) programs. The CC and staff interviewed also report that they | • Consider options that will minimize the need for the team to refer to outside agencies for services that are to be provided by the ACT team (e.g., vocational services).<br>• Explore opportunities for professional development for staff in specialty ACT positions (e.g. substance abuse treatment, public housing programs, etc.)<br>• Recruit staff members with expertise in ACT specialties who are capable of cross-training other staff in specialty areas. |

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| | | | are not qualified to provide counseling/psychotherapy and substance abuse treatment, so they refer to the co-located provider, day programs and partial hospitalization programs. As noted earlier in the report, the staff does engage members to consider treatment options, but it is not clear if the team provides a full spectrum of services directly. It appears that more than 10% of members who receive vocational support or substance abuse treatment receive it from external providers, and all members who require individual counseling are referred to external providers. | |
| O4 | Responsibility for Crisis Services | 1 – 5 (5) | The team reports they provide crisis services coverage 24 hours-a-day, and seven days a week. The ACT Team Clinical Coordinator reported the staff members continue to rotate as the primary on-call staff, and the on-call phone is required to be answered even during business hours. Per report, two staff are always available to go out after hours, and in some cases (e.g., medication issue) the Psychiatrist can be consulted after hours. Staff report a list of team contact numbers is provided to members; the team assists members to ensure easy access to the numbers (e.g., enter the numbers on member cell phones, prompting members to put the numbers on their refrigerators). The CC reports he is available to support staff 24 hours-a-day, seven days-a-week. | |
| O5 | Responsibility for Hospital Admissions | 1 – 5 (4) | Staff report the team works with members and is involved in most hospital admissions, but some members self-admit or work with family to seek admission without informing the team. Per data and CC interview, the team was involved in seven of the last ten hospital admissions. The CC reported that three members self-admitted. The CC and staff interviewed reported that they continue to follow | • The team should continue to work with members to discuss the pros and cons of informing the team of issues that may lead to hospitalization; attempt to address barriers to the team not being involved in all admissions. Work with informal supports to discuss the pros and cons of |

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| | | | the inpatient protocol and support the member from assessment to admission. | informing the team of issues that may lead to hospitalization and educate family on how the ACT team can support members in the community. |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5 (4) | Staff report that they are involved in most discharges, with some members discharging on their own or with assistance from their family. Staff report involvement in nine out of the ten most recent hospital discharges. Staff state they visit members in the hospital every 72 hours, as well as maintain regular contact with hospital social workers for discharge planning. | |
| O7 | Time-unlimited Services | 1 – 5 (4) | In the 12-month period prior to this review, six members graduated (i.e., need for services was reduced), and the CC projects an additional ten members will graduate in the upcoming 12 months. The CC reported that the team does not have time limits for members admitted to the team and remains the point of contact for those who transfer for higher level of care (e.g., 24 hour residential) until they are transitioned and stable.<br><br>Based on information provided, 33 members left the team in the past twelve months for reasons ranging from moving out of the service area, residential treatment referrals, graduation, and the death of seven members. Staff report twelve members were admitted to the team in the past six months. | • The team should track admissions and discharges off the team. |
| S1 | Community-based Services | 1 – 5 (4) | Staff estimates time spent in the community 70%-90% of the time. However, some members report contact with the staff primarily in the office, with those that receive medication observation reporting more frequent contact in the community. Based on review of ten member records randomly selected | • The agency should work with program staff to brainstorm ideas to increase community-based services. |

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| | | | for review, the ratio of services delivered in the community verses those delivered in the office showed a median of 64% face-to-face contacts in the community.<br><br>Staff report that they find it challenging to reach the recommended 80% face-to-face contacts in the community due to the other required daily tasks and demands placed on them. Some staff report that they start their day with medication observation routes, followed by attending the hour and a half morning meeting, an hour for lunch, and then are mandated to be in the clinic the last two hours of their shift to enter documentation. As a result, for some staff, there is less than two hours left in the eight hour work day to provide other face-to-face supports to members in the community.<br><br>Staff report they don't have working laptops, and when they had laptops, connectivity issues sometimes made it difficult to use computers in the field; the technology does not allow them to be as productive as possible when they have downtime in the field (e.g., when supporting members attending court). Some staff report it would be helpful if they had smart phones to communicate and coordinate with the team, to check email while out in the community, to assist with coordinating hospital discharges, etc. | |
| S2 | No Drop-out Policy | 1 – 5 (5) | The team reports that they continue to engage and retain members at a 97% rate. During the 12 months reviewed, three members refused services.<br><br>Per data provided and CC interview, in the past 12 months there were ten members referred to 24 | |

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| | | | hour residential care, which results in a transition off the team, and one member who was administratively transferred to another ACT team. | |
| S3 | Assertive Engagement Mechanisms | 1 – 5 (5) | The CC and staff interviewed reported that they continue to use engagement and outreach strategies such as medication observations, home visits, advocacy/support in mental health and criminal court, hospital visits, coordination with payee services, outpatient commitment, contacts with probation or parole officers, coordination with shelters, street outreach in areas members are known to frequent, and community resources to keep members engaged with the team and treatment. Based on records reviewed and team meeting observation, there is evidence staff plan and conduct outreach/engagement with members who are not in consistent contact with the team. | |
| S4 | Intensity of Services | 1 – 5 (2) | Ten records were reviewed to determine the average amount of face-to-face service time spent with each member. The average weekly amount of service time per member ranges from less than 9 minutes to about 145 minutes, with five of those members receiving less than 38 minutes per week. The team spends an average of 47 minutes per week in total service time per member. | • It is recommended that the team provide on average two hours/week or more of face-to-face contact for each member of the team.<br>• Explore what actions the team can take that could result in higher service intensity per member. Suggestions include creating targeted service agendas for appointments with members, increasing services provided through ACT staff, decreasing brokered services though outside agencies, sharing and/or reassignment of staff responsibilities, etc. |
| S5 | Frequency of Contact | 1 – 5 (3) | Some members receive medication observations services from the team daily to twice daily, and as a result those members have more contact with staff than other members on the team. Based on ten records reviewed, the average team rate of face-to- | • The ACT model is designed to deliver intense, frequent face-to-face services to members in their own communities. The team, network and RBHA should review potential barriers to staff maintaining a |

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| | | | face contacts with members over a month period ranges from .5 to 15.25 per week, but half received two or less contacts per week. The median face-to-face contact is 2.38 per week. | high frequency of contact with all members. |
| S6 | Work with Support System | 1 – 5 (3) | The staff reporting of contacts with member support systems varies greatly; estimates are that 25% - 70% of members have informal supports with which the team is in contact at least monthly. For those members with informal support systems, staff estimate contact ranges from weekly to monthly. The record review captured no informal support contacts for most members (7 out of 10); however in some cases the team did maintain a high frequency of contact with informal supports. Of ten member records reviewed, contact with informal supports ranged from an average of four times a week for one member, an average of weekly contact for one member, and an average of monthly contact for one member. During morning meeting there was some discussion, on occasion, of contact or plans to make contact with informal supports.<br><br>Based on available information, it appears the team is in contact with informal supports approximately one time per month on average. | • Continue to ensure that ACT staff review the potential benefits of engagement with informal supports, and attempt to secure a Release of Information (ROI) allowing staff to contact potential supports. |
| S7 | Individualized Substance Abuse Treatment | 1 – 5 (3) | The team continues to integrate some substance abuse treatment into regular member contact, but no formal, individualized treatment program is provided. Per SAS interview and records reviewed, no evidence of a structured, individualized counseling program (as provided by the ACT team) was found at the time of review.<br><br>Staff on the team report they are not able to provide individual SA counseling due to not being | • The SAMHSA ACT model does not require licensure or specific certification as a requisite for staff to provide SA treatment; training and experience are the focus. The team, network, RBHA, and ADHS need to explore if ACT staff in Arizona are allowed to provide individual substance abuse treatment directly or under the supervision of qualified staff. This may include |

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| | | | licensed and as a result the team relies on referrals to outside providers and staff co-located at the agency. As of the review, the co-located staff worked for the same agency as the ACT team, Lifewell Behavioral Wellness. | additional education, training, or changes to position expectations to allow for staff to provide individual substance abuse treatment.<br>• The ACT team has been incorporated into Lifewell Behavioral Wellness; the agency should explore opportunities for the SA program to support, train, or integrate into the ACT team. |
| S8 | Co-occurring Disorder Treatment Groups | 1 – 5 (2) | The SASs utilizes the activities and ideas compiled in a workbook, the *ACT Team Substance Abuse Group Workbook,* created by the RBHA. Staff report between 55 and 58 members on the team are identified with co-occurring disorders, and of those members, six to ten (approximately 15%) attend at least one meeting per month.<br>The ACT team's two SAS staff provide a Monday substance abuse group. Staff report the team was transporting members to a substance abuse group in the community on Fridays weekly, but due to staff turnover, that support has been more difficult to facilitate. | • The agency should provide enhanced training and support for specialists to provide the full array of substance use treatment services and minimize referrals to outside providers.<br>• The team should continue to engage members with identified with co-occurring disorders to attend the group offered through the team. Consider expanding the number of groups offered through the team and enhancing the curriculum. |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 – 5 (3) | The CC and SAS interviewed reported that the team is familiar with the Co-Occurring Disorder model. During interview the SAS used stages of change language and reported that he and the team continue to use motivational interviewing techniques to facilitate movement from pre – contemplation, to contemplation, and action stages. Staff reported that the team continues to view abstinence as a desirable goal, but favors harm reduction. There is some evidence the team relies on referrals to Alcoholics Anonymous (AA) as well as inpatient detox and rehabilitation. Staff reported | • The provider should provide training to staff in an integrated dual diagnosis stage-wise approach to treatment; use this as the standard approach when working with members who have co-occurring disorders. For example, work with members in early phases of recovery to build awareness of problems associated with use, seek family support, create pro/con lists related to use, etc. |

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| | | | they offer to attend the first meeting with members. The team does refer some members to 24 hour co-occurring residential treatment.<br>Based on documentation, observation of the team meeting and interviews there is evidence the team frequently offers the SA treatment group to members, but other interventions that align with a stage-wise approach to treatment were not as evident. For example, notes reflect some staff recommend detox/rehab facilities and instruct members to refrain from any substance use, including alcohol, illicit drugs, or tobacco. | |
| S10 | Role of Consumers on Treatment Team | 1 – 5 (1) | During time of the review, the CC reported that the team does not have a staff person who self identifies as an individual with lived experience with a mental illness. | • Recruit and hire an individual with a lived experience of mental illness to fill the open Peer Support Specialist (PSS) position on the team. |
| **Total Score:** | | **3.71** | | |

**ACT FIDELITY SCALE SCORE SHEET**

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

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| 6. Responsibility for Hospital Discharge Planning | 1-5 | 4 |
| 7. Time-unlimited Services | 1-5 | 4 |
| Nature of Services | Rating Range | Score (1-5) |
| 1. Community-Based Services | 1-5 | 4 |
| 2. No Drop-out Policy | 1-5 | 5 |
| 3. Assertive Engagement Mechanisms | 1-5 | 5 |
| 4. Intensity of Service | 1-5 | 2 |
| 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 | 2 |
| 9. Co-occurring Disorders (Dual Disorders) Model | 1-5 | 3 |
| 10. Role of Consumers on Treatment Team | 1-5 | 1 |
| **Total Score** | **3.71** | |
| **Highest Possible Score** | **5** | |