ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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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 an Evidence-Based Practice (EBP).

Method

On August 5 – 7, 2024, Fidelity Reviewers completed a review of the Terros Health – Priest Health Center 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 the Central Region of Arizona.

Terros Health provides a range of services, including primary medical care, behavioral health, and substance use treatment. The agency operates several centers in the Central Region of Arizona which includes four ACT teams. This review specifically focuses on the Priest Health Center ACT team.

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

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 6, 2024.
- Individual videoconference interview with the agency Health Center Director covering as the Clinical Coordinator for the team.
- Individual videoconference interviews with the Peer Support and Rehabilitation Specialists.
- Individual phone interviews with the Housing and Independent Living Specialists.
- Group videoconference interview with two Co-Occurring Disorders Specialists.
- Individual phone interviews with two members participating in ACT services with the team.
- Closeout discussion with the Health Center Director (acting Clinical Coordinator) and representatives from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for 10 randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; *Meet Your ACT Team* handout; member calendars; 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. It is a 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 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 & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Program Meeting: The team meets in person four days a week to review all members, discuss immediate needs, and plan staff interventions and support.
- Program Size: The team is of sufficient size to provide the necessary coverage to the 99 members with 11.5 full-time equivalent (FTE) staff.
- Responsibility for Hospital Discharge Planning: The team was involved in 100% of the 10 most recent psychiatric hospital discharges.
- Community-Based Services: The team excels (median 85%) at providing services to members in the community, rather than functioning as an office-based program.

- Assertive Engagement Mechanisms: Upon noticing a decrease or fluctuation in member engagement, the team utilizes motivational interviewing to reassess member needs in order to better support members. The team demonstrates consistent use of well-thought-out strategies and, when appropriate, uses street outreach and legal mechanisms to re-engage members.

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

- Team Approach: Increase the delivery of in-person contact with members by diverse staff, supporting a team approach. Diversity of staff interaction allows members access to unique perspectives and expertise of staff.
- Intensity of Services: Increase the duration of service delivery to members. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Evaluate how the team can engage or enhance support for members that receive a lower intensity of service.
- Frequency of Contact: 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.
- Co-Occurring Disorders Treatment Groups: 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.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 99 members with 10.5 full-time equivalent (FTE) direct service staff, excluding the prescriber and administrative staff. Positions on the team include two Registered Nurses, two Co-Occurring Disorders Specialists, one ACT Specialist, one Independent Living Specialist, one Housing Specialist, one Peer Support Specialist, one Rehabilitation Specialist, one Employment Specialist, and a 0.5 FTE acting Clinical Coordinator (CC), that is a Licensed Associate Counselor. The team has an appropriate member-to-staff ratio of approximately 9:1.	
H2	Team Approach	1 - 5 3	Staff interviewed reported 95% of members have contact with at least two team staff each week. Staff report using a geographic zone approach that rotates weekly to ensure members are contacted by more than one staff; engagement efforts are tracked on member calendars and documented in the member record. Per interviews, staff maintain caseload assignments solely for administrative purposes. Of the 10 randomly selected member records reviewed for a month period, a median of 40% received in-person contact from more than one staff from the team in a two-week period.	• Ideally, 90% of ACT members have in-person contact with more than one staff in a two-week period. Continue efforts to ensure all members on the ACT roster have in-person contact with more than one staff every two weeks; a diversity of staff allows members access to unique perspectives and expertise of staff. • Increase contact of diverse staff with members. The team approach ensures continuity of care for members and creates a supportive environment for staff, potentially reducing the burden of responsibility. ACT staff are cross trained to work as a transdisciplinary team rather than individual case managers. Further, ACT team staff collaborate on

				assessments, treatment planning, and day-to-day interventions.
H3	Program Meeting	1 - 5 5	Per interviews, the team meets four days a week to discuss all members on the roster; all staff, including the prescriber, are expected to attend on scheduled workdays. During the program meeting observed, the CC facilitated the discussion by announcing member names from the roster. For each member, staff reported on recent and planned activities, including missed appointments, hospitalizations, medication observations, jail visits, employment goals, housing needs and outreach attempts. The prescriber engaged in discussions with staff and provided guidance relating to member care. The CC provided clinical direction to staff relating to the prioritization of service delivery to address member needs.	
H4	Practicing ACT Leader	1 - 5 2	The 0.5 FTE CC provides up to four hours of in-person services to members each week. Staff reported team specialists are expected to deliver direct services to approximately 40 members weekly for 25 to 30 minutes per interaction, approximately 20 hours weekly. The CC provides direct services at approximately 20% of the productivity level expected from other ACT staff. Reported activities of the CC include providing onsite support to members in the office and completing medication observations in the community. Records reviewed lacked evidence of members receiving services from the acting CC.	• Continue efforts to provide in-person services to members. Optimally, the ACT CC delivers direct services to members accounting for at least 50% of the expected productivity of other ACT staff. • Given the importance of the CC role on the team, ensure that this position is consistently filled by appropriately trained and experienced staff that deliver direct care services to members.

			This item is dependent on the Provider productivity expectation.	
H5	Continuity of Staffing	1 - 5 4	Based on information provided, and reviewed with staff, five staff left the team during the past two years resulting in a turnover frequency of approximately 21%.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.
H6	Staff Capacity	1 - 5 4	In the past 12 months, the team operated at approximately 91% of full staffing capacity. There was a total of 13 vacant positions in the past 12 months. The Employment Specialist and one Co-Occurring Disorders Specialist positions were each vacant for four months.	• Continue efforts to retain qualified staff with the goal of operating at 95%, or more, of full staffing annually.
H7	Psychiatrist on Team	1 - 5 5	Staff report the team has one fully dedicated Psychiatric Nurse Practitioner (PNP) that works four 10-hour days a week, Monday through Thursday. Staff report the PNP is readily accessible to the team via phone and email, including after-hours. The PNP sees all members on the roster once a month, in the office and the community. Staff report the PNP will see members via videoconference when necessary. Per interviews with staff, it is typical for the PNP to be involved in all levels of member care. Of the 10 records reviewed, 90% showed the PNP delivering services to members at least once during a 30-day period; services were provided in the office and the community.	
H8	Nurse on Team	1 - 5 5	The team has two full-time Registered Nurses assigned to work with all members of the team. Staff report both Nurses provide services in the	

			office and community. The Nurses have staggered schedules; one works five days a week and the other works four, 10-hour days. Staff report both Nurses are available to the team for in-person communication in the office and are accessible via messaging platforms, phone and email. One staff reported Nurses are not scheduled to work weekends but are accessible via phone, or a video call to assist with member care. Of the 10 records reviewed, 70% showed the Nurses delivering services to members once during a 30-day period; services were provided in the office and the community.	
H9	Co-Occurring Disorders Specialist on Team	1 - 5 4	The team has two Co-Occurring Disorders Specialists (CODS). Both specialists have at least one year of experience providing substance use treatment services. Per a review of records for both specialists from the past two years for training related to substance use treatment, one had approximately seven hours and the other specialist had none. Neither CODS is responsible for providing the team with co-occurring disorders training and education; specialists are available to provide informal one-to-one discussions with staff.	• Provide eight hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. On ACT teams, CODS have the capability to cross-train other staff, providing guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model utilized by the team. • Ensure Co-Occurring Disorders Specialist staff are provided with regular supervision from a qualified professional.
H10	Vocational Specialist on Team	1 - 5 4	The team has one Rehabilitation Specialist (RS) and one Employment Specialist (ES). Both specialists are new to the team but have at least one year of experience assisting members in	• Provide ongoing training, guidance, and supervision to Vocational Specialist staff related to support and best practices that aid members to obtain competitive

			finding and retaining employment in integrated settings. A review of training records for the specialists over the past two years shows the RS received at least six hours of training focused on supporting individuals with serious mental illness in obtaining and retaining employment; there was no evidence of recent training for the ES. Staff report the RS participates in quarterly meetings with the contractor with a Regional Behavioral Health Agreement.	positions in integrated work settings. Consider focusing training on techniques to engage members to consider employment; job development strategies; the importance of supporting in-person employer contact soon after members express an employment goal; and the provision of follow-along supports to employed members.
H11	Program Size	1 - 5 5	At the time of the review, the team was comprised of 11.5 FTE staff, including the PNP. The team is of sufficient size to adequately provide services to members.	
O1	Explicit Admission Criteria	1 - 5 5	The team has a clearly defined target population. Staff interviewed reported the team receives referrals internally, and externally from providers in the community, hospitals and the Regional Behavioral Health Agreement. The team utilizes *Mercy Care ACT Admission Criteria* to assess potential admissions. The CC is primarily responsible for conducting initial screenings, but all team staff are trained and able to conduct the screenings. The initial screening, conducted in-person or via videoconference, allows the CC to discuss potential members past hospitalizations, daily living activities, independent living skills, and employment status. The CC then summarizes this screening for the PNP to review. The PNP coordinates with the member's current psychiatric prescriber, reviews medical records,	

			and is responsible for making the final decision regarding admission. If the PNP declines the referral, the CC and PNP provide treatment recommendations, followed by a complex case review with the contractor with a Regional Behavioral Health Agreement.	
O2	Intake Rate	1 - 5 5	Per the data provided, the team maintains an appropriate rate of admissions. The highest intake rate occurred in April, with four (4) new admissions.	
O3	Full Responsibility for Treatment Services	1 - 5 3	In addition to case management, the team provides psychiatric services and medication management, and substance use treatment services. Staff reported providing employment support to approximately 10 members. Staff support employed members by checking in regularly to assess their wellbeing and address any changes in needs or goals. For members seeking employment, staff assist with resume development, mock interviews, hygiene education, obtaining professional clothing for interviews, and referrals to employment programs. Staff reported six members receive employment supports from outside providers, with three participating in a Work Adjustment Training Program (WAT). Per interviews, the team does not provide counseling or psychotherapy services; members in need of counseling services are referred to outside providers or providers within the larger agency.	• In the EBP of ACT, services are fully integrated into a single team with no, or very few, referrals to external providers. • Counseling/psychotherapy is made available to members of ACT teams and is provided by ACT staff. This staff will also act as a generalist within the team. Ensure future staffing includes a person with qualifications to provide counseling/psychotherapy to members of the team. • Educate staff on the benefits of ACT staff engaging and directly supporting members with rehabilitation and competitive employment goals rather than engaging them to participate in temporary WAT activities or employment services with brokered 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. Educate representatives of

			Staff report up to 16 members reside in settings where ACT services are duplicated.	partner systems how ACT staff can provide supported housing services in order to minimize the number of members in staffed settings.
O4	Responsibility for Crisis Services	1 - 5 5	Per interviews, the team provides 24-hour crisis services to members. Upon onboarding to the team, members are provided with the *Meet Your ACT Team* handout that lists the positions on the team, the name of the staff in each position, the description of each position, and the contact information for each staff; the handout also includes the office/agency phone number and the team's on-call phone number. Staff, excluding the PNP and Nurses, rotate on-call responsibilities weekly. Two staff are on-call per week and the CC serves as the backup to the on-call staff. When a distressed member calls the on-call line, staff attempt de-escalation over the phone. When unsuccessful, staff will meet members in the community to assess and provide support. On-call staff will discuss the member's symptoms with the PNP and if instructed, staff will transport the member to the hospital. Of the two members interviewed, both reported awareness of the team's availability after-hours via the on-call line.	
O5	Responsibility for Hospital Admissions	1 - 5 4	Staff stated that the team makes every effort to prevent hospitalization and keep members within the community. When a member is experiencing an increase in symptoms, efforts are made for the member to be triaged by the PNP either at the office or in the community.	• ACT teams performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. • Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with

			When inpatient stabilization is recommended, and members agree, staff will coordinate with the inpatient team, transport the member to the hospital, and stay with the member through the admission process. Reviewers requested information regarding the 10 most recent psychiatric hospital admissions. Per a review of data with staff regarding these admissions, the team was directly involved in 70%. The 10 admissions occurred over a five-month period.	opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build a rapport with natural supports.
O6	Responsibility for Hospital Discharge Planning	1 - 5 5	Per interviews, discharge planning begins upon admission. Staff see members within 24 hours of admittance and contact with members occurs every 48 hours. Staff advocate for staffings with the inpatient team to occur immediately. Staff reported that most frequently hospitalized members have guardians, and the team works diligently to ensure their involvement. Inpatient teams often recommend staffed residential settings for member discharges. However, staff work to educate these teams on why such settings are not suitable for ACT members, as they duplicate services already provided. Staff participate in discharge staffings, transport members home or to the agreed upon placement, and participate in scheduled intakes. Staff report the team follows a discharge protocol which includes an appointment with the PNP and Nurse within 48 hours of discharging and five consecutive days of contact from team staff.	

			Reviewers requested information regarding the 10 most recent psychiatric hospital discharges. Per a review of data with staff regarding these discharges, the team was directly involved in 100%. The 10 discharges occurred over a five-month period.	
O7	Time-unlimited Services	1 - 5 5	Data provided showed one member graduated from the team in the past 12 months. Per interviews, four members are expected to graduate in the coming year. Staff reported the team uses a step-down system to help prepare members for services at a lower intensity. The step-down system includes tapering members off medication observations and gradually reducing contact from staff to a lower frequency.	
S1	Community-based Services	1 - 5 5	Staff interviewed reported 75 - 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 85% of the time in the community.	
S2	No Drop-out Policy	1 - 5 5	According to data provided and reviewed with staff, the team had four members leave the program in the past year. The team retained approximately 96% of the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 - 5 5	Staff reported that when members are difficult to engage, the team leverages natural supports and attempts to re-educate both the members and their supports about ACT services. Staff recognize member needs fluctuate and use motivational interviewing to reassess and address current needs, increasing the likelihood of sustained engagement.	

			When members stop engaging, decline, or refuse services, official engagement efforts begin; the team makes four direct attempts to re-connect with members weekly, for eight consecutive weeks. Staff reported three of the four attempts must occur in the community. Attempts include conducting home visits, completing physical searches of known hangouts, local shelters, and food pantries. The remaining contact can occur from the office and may include calling hospitals, emergency contacts, natural supports, the medical examiner's office, and law enforcement. Of the 10 member records reviewed, 30% of members were on outreach. Records showed staff attempting re-engagement efforts daily for four to five days in a row until making contact with the members.	
S4	Intensity of Services	1 - 5 2	Per a review of 10 randomly selected member records, during a month period before the review, the median amount of time the team spends in-person with members is 38.13 minutes per week. The highest weekly average for in-person services was 126.5 minutes, and the lowest was 0.5 minutes. Phone contact is also used by the team and was evidenced in four records. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the duration of service delivery to members. ACT teams provide an average of two (2) or more hours of in-person services per week to help members with serious symptoms maintain and improve functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms. • 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.

S5	Frequency of Contact	1 – 5 2	Per records reviewed, staff provided a median frequency of 1.38 weekly in-person contacts to members. The record with the highest frequency was 3.75 in-person contacts per week. The record with the lowest frequency was 0.25 weekly in-person contacts.	• 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.
S6	Work with Support System	1 - 5 3	Per data provided and reviewed with staff, approximately 67 members have natural supports; 20 – 25 natural supports were engaged by staff at least once in the past 30 days. Staff engage natural supports during home visits and encourage them to participate in member appointments. A weekly group is offered for members and their natural supports. During the program meeting observed, natural supports were discussed for 18 members; with direct contact discussed for eight members. Records reviewed showed an average of 1.3 contacts with members' natural supports during a 30-day period. Of the two members interviewed, one reported the team has contact with their natural supports once a month.	• Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four (4) per month for each member with a support system. • Assist members in developing a natural, community-based support system. Active participation with peer run programs are a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact.
S7	Individualized Co-Occurring Disorders Treatment	1 - 5 4	Per data provided there are approximately 61 members with co-occurring disorders on the team. Per interviews, both CODS staff provide regular, structured, individualized substance use treatment to approximately 40% of members with co-occurring disorders. Individual treatment ranges from 30 to 45 minutes per session and sessions occur up to four (4) times weekly. Staff report the individual substance use treatment provided by specialists is guided by	• Explore training on strategies to engage members in substance use treatment. Document the offering of those services and the delivery of individual treatment to members with co-occurring disorders. • Consider reviewing documentation of individual treatment during supervision with CODS to ensure it provides sufficient detail and that services align with the member's stage of change.

			the *stages of change* model, *Integrated Dual Disorder Treatment* (IDDT) principles, cognitive behavioral and dialectical behavior therapies (CBT/DBT), the evidence-based practices (EBP) of *harm reduction* and *motivational interviewing*, as well as agency curriculum. Per a review of the 60 calendars provided for members with co-occurring disorders, approximately 60% were seen by CODS at least once monthly, 20% were seen four times a month and 20% were not seen during the month period. Of the 10 records reviewed, 80% were members with co-occurring disorders. Of those, one record showed one 24-minute individual co-occurring disorders treatment session documented during the month period reviewed. An additional four records showed a CODS meeting with members up to two times monthly; however, the nature of the services provided in those encounters appeared to be general case management.	
S8	Co-Occurring Disorders Treatment Groups	1 - 5 2	Per interviews, the team offers four (4) weekly substance use treatment groups; groups are held at the office and staff report up to six members attend regularly. Review of group sign-in sheets from the month prior to the review showed that eight percent (five) unique ACT members with co-occurring disorders attended these groups.	• On ACT teams, all staff engage members with co-occurring disorders to participate in treatment groups, based on their stage of change, with content reflecting stage-wise treatment approaches. • Consider adapting one group for members in earlier stages and one group for members in later stages, allowing staff to adjust interventions to better serve members in different stages of change.

S9	Co-Occurring Disorders Model	1 - 5 4	Staff interviews reflected the team's knowledge and utilization of motivational interviewing techniques and harm reduction strategies. Staff used non-judgmental language and reported familiarity with the principles of a stage-wise treatment approach to interventions; most staff demonstrated the ability to match interventions to the appropriate stage of change. Staff reported using a person-centered approach to guide treatment; staff do not refer members to peer-run meetings or detoxification programs but will support member choice in pursuing or participating in those treatment options. Per interviews, staff celebrate member's willingness to engage in recovery focused services both on and off the team. Staff reported historically members were referred to agency providers for medications for opioid use disorder (MOUD); however, the PNP is now licensed to prescribe Suboxone and able to help most members in need of MOUD services. Staff have been trained to recognize the signs of an opioid overdose and are equipped with Narcan and trained in its administration. Per interviews, staff are now providing Narcan training to members. During the program meeting observed, staff used recovery focused language while discussing interventions for some (10%) of the members with co-occurring disorders; some of the interventions discussed included a referral to the larger agency's intensive outpatient program	• 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.* • Ensure treatment plans are recovery focused, and outline steps the team will take to address substance use while supporting the member in recovery. Support members to identify a *reduction of use* goal when a desire for abstinence is expressed.

			and follow-up conversations about supportive sober living placements. Among the eight member records reviewed with co-occurring disorders, all had current treatment plans. Seven plans lacked substance-use treatment goals and did not identify how the team planned on supporting the member's co-occurring disorders needs.	
S10	Role of Consumers on Treatment Team	1 - 5 5	The team has at least two staff with personal lived or living psychiatric experience; both share their story of recovery with members, when appropriate, and share the same level of responsibility as other ACT staff. Staff highlighted the value of having team members with personal lived psychiatric experience, as it fosters genuine conversations and offers a different perspective. Both members interviewed were aware of peer staff on the team.	
Total Score:		**115**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
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	4
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	3
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	4

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	5
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	2
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	2
9. Co-occurring Disorders Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.11**	
Highest Possible Score	**5**	