ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: John Hogeboom, Chief Executive Officer
Stacey Ellis, interim Clinical Coordinator | CBI Site Administrator

From: Vanessa Gonzalez, BA
Jasmine Davis, MS
AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with 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 September 11 – 13, 2023, Fidelity Reviewers completed a review of the Community Bridges Incorporated (CBI) Forensic Assertive Community Treatment Two (FACT 2) 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.

Community Bridges, Inc. has several locations throughout Arizona. Services provided include supportive housing, crisis stabilization, ACT, and integrated healthcare. The agency operates three ACT and two Forensic ACT teams in the Central Region of Arizona. The individuals served through the agency are referred to as "clients" and "members" 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 the ACT team's program meeting on September 13, 2023.
- Individual video conference interview with the interim Clinical Coordinator (CC).

- Individual video conference interviews with the Employment and ACT Specialists, one Co-Occurring Specialist, and one Nurse for the team.
- Individual phone interview with one member participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; resumes for Vocational and Co-Occurring Specialists' staff; IDDT group sign in sheets, Outreach Protocol from Mercy Care, *Fact 2 Contact List,* and the following treatment manuals cover pages for reference:
    - *Integrated Dual Disorders Treatment – Recovery Life Skills Program*
    - *Mercy Care Provider Manual – Outreach, Engagement and Closure*

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:

- The team has an appropriate caseload ratio of one staff to ten members allowing for adequate and diversity of coverage.
- The team meets four days a week to discuss all members. During the program meeting observed, multiple staff contributed to the discussion and reported on members' stage of change, recent and upcoming home visits, and contact with natural supports.
- The ACT team has a clearly defined target population with whom they work; all staff are trained to conduct screenings of referrals and report no outside pressure to admit members.
- The team has 24/7 crisis services available to members on the team and reports assisting members in the community when necessary.

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

- The Team Lead/Clinical Coordinator position is vacant. An essential role on ACT teams is the Clinical Coordinator. Ensure the position is consistently filled by appropriately trained and experienced staff that deliver direct care services to members.
- A low rate of frequency and intensity of services is delivered to members. Increase the intensity and frequency of contact with members. Ideally, members are seen on average four times a week for at least two hours or more a week.
- The Peer Support position is vacant. Fill the vacant Peer Support Specialist position as they offer important skills and insights to members and staff on an ACT team. Consider utilizing current staff with lived experience of psychiatric recovery for their insight into the member perspective and potential for enhancing trust and rapport between members, their supports, and the ACT team by using appropriately timed and client-centered self-disclosure to inspire hope and model recovery.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team serves 79 members with eight full-time equivalent (FTE) direct service staff, excluding the Psychiatrist and the Psychiatric Nurse Practitioner. The team has a member-to-staff ratio of 10:1. Staff on the team include two Nurses, one Co-Occurring Specialist (COS), ACT Specialist, Employment Specialist, Rehabilitation Specialist, Housing Specialist, and Independent Living Specialist.	
H2	Team Approach	1 – 5 3	Staff reported following a weekly zone rotation in an effort to meet with different members weekly. One member interviewed reported meeting with two different staff in the past week. The team tracks contact with members in the morning meeting and by documenting in progress notes. Per review of ten randomly selected member records, for a two-week period, 40% of members received in-person contact from more than one ACT staff.	• Ensure all members are seen by diverse staff as this is a crucial ingredient of the evidence-based practice. Ideally, 90% of ACT members have in-person contact with more than one staff in a two-week period.
H3	Program Meeting	1 – 5 5	Staff interviewed reported meeting four days a week for one hour on Monday, Tuesday, Thursday, and Friday. Most staff are assigned to work four ten-hour days, attending the program meetings on the days scheduled to work. The assigned prescriber also attends the program meeting on	

			the days scheduled to work. During the program meeting observed, all staff participated in the discussion which included recent home visits, co-occurring treatment sessions, contact with member natural supports, medication observations, member's stage of change, upcoming appointments, member's hospitalization status, and member's incarceration status. All members were reviewed during the program meeting.	
H4	Practicing ACT Leader	1 – 5 1	At the time of the fidelity review, the ACT team did not have a Clinical Coordinator. ACT staff reported a new Clinical Coordinator has been hired and has a future start date. The CBI site administrator participated in the interview as the Interim Clinical Coordinator. The Interim Clinical Coordinator began coverage in July of 2023 and reported spending less than ten hours per month delivering direct services to members.	• Given the importance of the Clinical Coordinator role on the team, ensure the position is consistently filled by appropriately trained and experienced staff that deliver direct care services to members. • Optimally, the ACT CC delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff. Practicing ACT leaders can engage in a range of member care needs including providing individual or group counseling/psychotherapy, providing support and advocacy at mental health court, participating in inpatient psychiatric staffings, shadowing and mentoring specialists delivering specialized services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery.

H5	Continuity of Staffing	1 – 5 3	Based on data provided, nine staff left the team in the past two years resulting in a turnover rate of 41%. The positions with the most turnover were the Clinical Coordinator and Co-Occurring Specialist.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion. • If not done so already, attempt to identify factors that contributed to staff turnover or that support retention. Consistency in staffing contributes to building therapeutic relationships with members and their supports, as well as reducing potential burden on staff.
H6	Staff Capacity	1 – 5 2	The team operated at 60% staff capacity during the past 12 months. There was a total of 57 vacant positions. The Housing Specialist position has been vacant for 10 months, the second COS position has been vacant 11 months, and the Nurse position had been vacant for 10 months.	• Continue efforts to retain qualified staff with the goal of operating at 95%, or more, of full staffing annually. • The timely filling of vacant positions also helps to reduce the potential burden on staff. 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	At the time of the review, the team had two full-time Prescribers, including a Psychiatrist and a Psychiatric Nurse Practitioner that recently started with the team and is transitioning to take over the Psychiatrist's case load once fully licensed. The Prescribers conduct doctor-to-doctor meetings with members who are inpatient, prescribes medications, and sees members once a month and as needed. Records reviewed and interviews with staff confirmed the Psychiatric Nurse Practitioner sees members in the office, community, and	

			through video conference per some members' request. The Psychiatrist and Psychiatric Nurse Practitioner work four ten-hour days and attend the daily team meeting on the days they are assigned to work. Staff reported both Prescribers can be reached by phone, in-person, by email and after hours and weekends if needed.	
H8	Nurse on Team	1 – 5 5	The ACT team has two full-time Nurses that provide injections, medication education, coordination of care with facilities and hospitals, attend specialty appointments, and provide health education to members of the ACT team. Staff reported both Nurses work four ten-hour days and alternate phone coverage each weekend. Per records reviewed and staff interviewed, the Nurses most often see members in the community versus the office. The Nurses are easily accessible via phone, in-person, or by email. The member interviewed reported that the Nurses being important advocates for their mental health. Multiple staff noted that the Nurses occasionally provide coverage for other ACT teams when Nursing positions are vacant, or staff are out.	• Monitor and minimize the amount of time the Nurses spend providing coverage to other ACT team members.
H9	Co-Occurring Disorder Specialist on Team	1 – 5 3	The ACT team is staffed with one COS that has been in the role for less than one year, is a Licensed Master Social Worker, and is working toward clinical licensure. No training records for the COS were provided to reviewers.	• Provide annual training to Co-Occurring Specialists in co-occurring disorder treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of

			The COS receives clinical supervision once a week for one hour by a Licensed Clinical Social Worker.	*harm reduction*; and *motivational interviewing*. On ACT teams, COS 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 disorder model utilized by the team. • Optimally, ACT teams are staffed with two COS, each with one year or more of training/experience providing substance use treatment services.
H10	Vocational Specialist on Team	1 – 5 4	At the time of the review, the team had two Vocational Staff, an Employment and a Rehabilitation Specialist. The Employment Specialist has been with the team since February 2022 and the Rehabilitation Specialist has been with the team since November 2022. Prior to working on the ACT team, the Employment Specialist worked for another ACT team for five years working with people with an SMI. The Rehabilitation Specialist had no prior experience providing services in rehabilitation or employment services before working with CBI. Training records for Vocational Staff were not provided to reviewers.	• Provide ongoing training, guidance, and supervision to Vocational Staff related to support and best practices that aid members to obtain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, employer engagement, and follow-along supports.
H11	Program Size	1 – 5	At the time of the review, the team was composed of 10 full-time staff including the Psychiatric Nurse Practitioner and Psychiatrist. The Clinical	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, a minimum of 10 direct service staff, allows the team to consistently provide diverse

		5	Coordinator, Peer Support Specialist, and second Co-Occurring Specialist position were vacant. *This item does not adjust for the size of the member/member roster.*	coverage; helps to prevent potential staff burn-out; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member.
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. New referrals are usually received from Mercy Care, mental health facilities, and parole and probation officers, since the team is a Forensic Assertive Community Treatment (FACT) team. The expectation is that all staff are trained in the screening process for a new admission. After staff complete the screening, they will discuss the potential member with the Prescriber and the team to determine if the member meets criteria.	
O2	Intake Rate	1 – 5 1	Per data provided, and reviewed with staff, the team had an intake rate of 23 new members over the past six months. The month with the highest admission was July with 18 new members added to the roster due to the closing of the CBI FACT 3 team. During July, the team had four vacant staff positions.	• Ideally, new intakes should not exceed six each month for a fully staffed team. Consider staffing capacity when admitting new members to the team to alleviate the potential burden on staff.

O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric medication management services, psychotherapy/counseling, co-occurring disorders treatment, and employment and rehabilitative services. Based on staff interviews and data provided, 15 members are in housing where services provided by the ACT team are duplicated such as attending groups or medication observation. Staff interviewed reported proving supports for five members are currently working and at least ten members are currently engaged in the job search activities. One member attends a Work Adjustment Training program. The team has one COS providing individual and group substance use treatment services to members with a co-occurring disorder. Importantly, the COS is trained in general mental health counseling and see approximately three members for non-COD related counseling. All members are seeing the ACT team Psychiatrist or Psychiatric Nurse Practitioner except for one member.	• ACT teams assist members to find housing in the least restrictive environments, which can reduce the possibility for services overlapping with other housing providers. Help members to explore low-income housing options to increase their housing choices. For members with histories that limit availability of housing options, consider legal measures to expunge criminal records.
O4	Responsibility for Crisis Services	1 – 5	Per interviews with the staff, the team provides 24/7 crisis services to members of the team. Staff reported the rotation of the on-call responsibility changes daily among staff, and a CBI Clinical	

		5	Coordinator is always on back-up to provide clinical support to on-call staff. Staff provide the crisis line to members and their natural supports at the time of admission. The ACT staff are expected to respond to every call and mobilize into the community when needed. The member interviewed reported knowing about the ACT on-call line and had used it in the past. Staff provide members with the *Fact 2 Contact List* which includes all staff contact information, as well as the crisis on-call number.	
O5	Responsibility for Hospital Admissions	1 – 5 2	Per review of data relating to the ten most recent psychiatric hospital admissions with staff, which occurred over a two-month time frame, the team was directly involved in 30%. Staff report that when members notify the team of the desire for psychiatric inpatient treatment, the team will staff the member with the Psychiatrist. When possible, the member is evaluated directly by the Psychiatrist. Staff report transporting members to the inpatient unit and remaining with members until admitted. For the admissions the team was not directly involved, staff reported that those members self-admitted.	• ACT teams performing to high fidelity to the model, are directly involved in 95% or more of psychiatric admissions. • Evaluate what contributed to members not seeking team support prior to self-admission. Attempt to determine the reasons some members avoid using the team on-call resource. • Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions. • Maintain regular contact with members and their support networks, both natural and formal. This may result in earlier identification of issues or concerns relating to members, allowing the team to offer

				additional support, which may reduce the need for hospitalization.
O6	Responsibility for Hospital Discharge Planning	1 – 5 3	Per the review of data relating to the last ten psychiatric hospital discharges with team staff, the team was directly involved in 40% of which occurred over a two-month period. Staff reported that discharge planning begins directly upon notice of admission. Staff reported that they have a five-day follow-up protocol and aim to have the member seen by the Psychiatrist in 72 hours or less. Staff report that their priority is to ensure members have a secure place in the least restrictive environment possible for the member to return to. For the discharges the team was not involved in, often staff were not notified of member admission, thus were unaware of the need to coordinate care. In addition, the follow-up protocol the team follows was not completed.	• Ideally, ACT teams are directly involved in 95% or more of psychiatric discharges. • Track member discharge coordination, including visits to members that are inpatient. This may prevent lapses of coordination with the treatment team which may result in earlier identification of issues or concerns relating to members, allowing the team an opportunity to offer additional supports. • Continue to build relationships with inpatient treatment teams and use resources available to advocate for member care. Some teams create business cards with team information that members can carry on their person to reference when interacting with other agencies/providers and expedite coordination of care.
O7	Time-unlimited Services	1 – 5 5	According to data provided and reviewed with staff, zero members graduated with significant improvement from the team in the last 12 months. Staff report that the team utilizes a level of care ACT exit screening tool when considering graduation or a step down in level of care services.	
S1	Community-based Services	1 – 5	Staff interviewed reported 75 - 80 % of in-person contacts with members occur in the community. Staff reported that with vacant staff positions, that	• Optimally, 80% or more of services occur in members' communities where staff can directly assess needs, monitor progress,

		4	number may actually be lower. A member reported having frequent home visits. Results of ten randomly selected member records reviewed show staff provided services a median of 72% of the time in the community.	model behaviors, and assist members in using resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had six members drop out of the program in the past year. The team retained 99% of the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff reported that the team aims to contact each member at least four times per week, noting these should be in-person and last at least 30 minutes. Staff provided the *Mercy Care Provider Manual – Outreach, Engagement, and Closure* for review. Of the ten records reviewed, four members were on outreach at some point during the month period reviewed. One member's record showed two outreach attempts over the period reviewed. During the program meeting observed, outreach attempts and coordination were not consistently documented. The records reviewed demonstrated street outreach in the community, and phone outreach, including to natural supports.	• When members miss scheduled appointments or are not seen at the frequency of ACT services, ensure a team discussion occurs during the program meeting to plan follow up care. Make certain those outreach activities are documented in member records. • Consider identifying factors that would initiate immediate member follow-up from the team (e.g., missed psychiatric/nurse appointments, missing two scheduled visits with staff specialists).
S4	Intensity of Services	1 – 5	According to the ten randomly selected member records, the median amount of time the team spent in-person with members was 12.5 minutes	• Increase the duration of service delivery to members. ACT teams provide an average of two (2) or more hours of in-person services

		1	per week during the month period reviewed. The average documented time ranged from 0 to 77.5 minutes. The median phone service duration was less than one minute. *The fidelity tool does not accommodate delivery of telehealth services.*	per week to help members with serious symptoms maintain and improve their 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. • Ensure staff are trained in appropriate documentation standards so that services and service time are accurately reflected in members' medical records.
S5	Frequency of Contact	1 – 5 1	The median weekly in-person contact for ten members was less than one contact per member per week, with a high of 2.50 and a low of 0.00 contacts per week. Seven out of ten of the records reviewed showed a median of less than one contact per week (0 - .75). The team had a higher rate of phone contacts per week, with a 1.50 median contacts in the month reviewed. Staff reported that slightly lower than 50% of members are being seen by more than one member of staff per week, noting that staff vacancies have been difficult to manage. A member reported seeing multiple staff in person during the previous week.	• Improved outcomes are associated with frequent contact. Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to receive ongoing support. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. Those contacts should be individualized and align with treatment goals identified. • 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	Staff interviewed reported that approximately 32 members have a natural, unpaid support that the team connects with. Staff report the goal is to be	• Increase contacts with natural supports to an average of four (4) per month for each member with a support system. As much as

		2	in contact with natural supports that are involved in member care at least once per week. Natural supports were discussed for some of the members reviewed during the morning meeting. Records reviewed indicated three out of ten records had documentation of staff collaboration with natural supports. Records demonstrated natural support listed at the top of treatment plans. A member reported that there is regular contact between ACT staff and their natural support during home visits. According to the record review, the average team contact with natural supports per month for ten records was 0.80.	possible, contacts with natural supports should occur during the natural course of delivery of services provided to members. • Continue efforts to engage members' natural support systems as key contributors to the member's recovery team. Consider the role of staff to model recovery language and provide suggestions to family members and other natural supports how they can support member care.
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 4	According to data provided and reviewed by staff, there were 48 members on the team with a co-occurring disorder (COD) diagnosis at the time of the review. Staff interviewed reported varied counts for how many of the members were receiving structured, individualized substance use treatment. Numbers ranged from 15 to 30 members, with sessions ranging from informal discussions for members in pre-contemplation to 190 minutes of formal individualized support. According to member records, six out of ten members were identified as having a COD. Two of those six received individualized substance use treatment sessions during the month period reviewed.	• Continue efforts to increase the time spent in individual treatment sessions and increase the number of members engaged so that the average time is 24 minutes or more, per week across the group of members with co-occurring disorder diagnoses. • All staff on ACT teams engage members with co-occurring disorder diagnoses to consider participating in substance use treatment. Explore training on strategies to engage members based on their stage of change.

S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	One Co-Occurring Specialist runs two substance use treatment groups per week. The groups utilize an *Integrated Dual Disorders Treatment – Recovery Life Skills Program* manual for treatment. Data provided included that 48 members currently have active co-occurring disorder diagnoses. Based on co-occurring group sign-in sheets for the month prior to the review six (13%) of those members attended a substance use disorder treatment group for the month period reviewed.	• Ideally, 50% or more of applicable members participate in a co-occurring group. • On ACT teams, all staff participate in engaging members with a co-occurring disorder diagnosis to participate in treatment groups. Ensure specialists, not only the COS, engage members to consider group treatment. • Staff may benefit from training on strategies to engage members in group substance use treatment.
S9	Co-Occurring Disorders Model	1 – 5 3	Staff report that the team uses the "IDDT treatment model." Some staff noted referring members to peer-run recovery groups or detoxification services when needed. Staff reported they will often work to get members into inpatient or residential treatment when they report they are actively using, focusing psychoeducation on the negative impact of substance use. Some staff reported that the ideal goal is abstinence yet recognized the importance of harm reduction. During the staff meeting observed, the stage of change was identified for members with a co-occurring disorder diagnosis. Of the six member records with a co-occurring disorder diagnosis, four had treatment plans that identified substance use (treatment) goals. Goals identified included language such as "sobriety,"	• Provide all ACT team staff with annual training and ongoing mentoring in a co-occurring disorders model, such as *Integrated Treatment for Co-Occurring Disorders,* the principles of *stage-wise approach* to interventions, the evidence-based practice of *harm reduction*, and *motivational interviewing*. • Consider reviewing with staff techniques to introduce recovery language into conversation with members and support systems. Consider monitoring documentation for use of recovery language. • Ensure treatment plans are written in the member voice, identifying goals and individual needs. Ensure members have the

			"substance abuse," and "clean." Substance use treatment notes indicate the member's stage of change.	ability to identify goals to reduce use when abstinence is not their explicit goal.
S10	Role of Consumers on Treatment Team	1 – 5 1	At the time of the review, the Peer Support Specialist position was vacant. Staff report that there are staff on the team with lived experience of mental health or substance use treatment, however they do not share their personal experiences with members.	• Ideally, the team is staffed with one or more individuals with personal lived experience of psychiatric recovery. Confirm member perspective is represented on the team. Educate staff and members about the role of staff on the team that have disclosed lived experience. • Staff sharing their experience of psychiatric care can offer members hope. Consider sharing these stories, when appropriate, with members.
Total Score:		**92**		

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	1
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	2
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Co-Occurring Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	4
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	1
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	2
6. Responsibility for Hospital Discharge Planning	1-5	3

7. Time-unlimited Services	1-5	5
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	3
4. Intensity of Service	1-5	1
5. Frequency of Contact	1-5	1
6. Work with Support System	1-5	2
7. Individualized Co-Occurring Disorder Treatment	1-5	4
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	**92**	
Highest Possible Score	**3.29**	