

ASSERTIVE COMMUNITY TREATMENT (ACT) FIDELITY REPORT

Date: November 9, 2015

To: Pete Tomasello, Clinical Coordinator

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

Method

On October 20-21, 2015, Jeni Serrano and TJ Eggsware completed a review of the Southwest Network Hampton 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.

The Hampton clinic is located at 1440 S. Country Club Dr. in Mesa, Arizona. This ACT team currently serves 93 members and has recently gone through staff changes since last year's review. The team's prior Employment Specialist was promoted to the position of Clinical Coordinator (CC) in January, 2015. The Hampton ACT team includes staff who have been with the team for many years, including their Psychiatrist (since 2004), Nurse (since 2004), Rehabilitation Specialist (formerly the team Substance Abuse Specialist, on the team since 2009), and Independent Living Specialist (on the team since 2000). The team currently has three vacancies and had two staff who were on extended leave-of-absence during this review period.

The individuals served through the agency are referred to as "members" so that term will be used in this report.

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

- Observation of a daily ACT team meeting on October 21, 2015
- Individual interview with Clinical Coordinator (i.e., Team Leader)
- Individual interviews with Housing Specialist (HS), Nurse, and Employment Specialist (ES)
- Individual interviews with two members who receive ACT services
- Group interview with three members who receive ACT services.
- Charts were reviewed for ten members using the agency's electronic medical records system
- Review of agency *Closure for Lack of Engagement Desktop Procedure, Act exit criteria screening tool and Admissions Forms.*

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:

- The ACT team benefits from having two Nurses on staff. The ACT Nurse position is considered a critical ingredient in successful ACT teams. Having two Nurses expands the team's capacity for delivering vital services such as medication administration, health and wellness education, Primary Care Physician (PCP) coordination, and involvement in treatment planning.
- The ACT team takes full responsibility for crisis services. The approach used by the team focuses on providing after-hours care with the same intensity as during normal business hours.
- The team does not immediately amend or discharge members from services due to failure to keep appointments, or for lack of engagement. The staff is persistent and use street outreach as well as having the Nurses come to them to administer medications in an attempt to engage and educate members in treatment.

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

- The agency needs to ensure that there is proper psychiatrist coverage; the team Psychiatrist was on extended leave of absence and has recently returned part time.
- The agency needs to continue to monitor and evaluate activities of the CC in order to increase community direct services to at least 50% of the time providing direct services.
- The agency needs to fill the open ACT staff positions as soon as possible; it appears many of the reduced scores identified in this review over the prior year's review are due, in part, to the shortage of staff. This will help to decrease caseload size, to support a team approach, and to increase the intensity, frequency, and diversity of services provided through the team.
- Both Substance Abuse Specialist (SAS) positions should be filled with experienced staff so the team will be better positioned to provide individual SA treatment based in an integrated treatment model. The team currently does not have any SASs, therefore does not currently provide regular, direct, substance abuse treatment to members with co-occurring disorders.
- 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.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (4)	The team serves 93 members with eight staff who provide direct services (excluding the Psychiatrist and the Transportation Specialist (TS) on extended leave for over three months), resulting in a 12.1 staff ratio.	<ul style="list-style-type: none"> Recruit qualified staff to fill vacant positions, including both SAS and the Peer Support Specialist (PSS) positions.
H2	Team Approach	1 – 5 (5)	ACT members receive direct, face-to-face contact with multiple staff 90% of the time, based on records reviewed. Members interviewed reported that they are assigned a primary case manager; however, they do have contact with multiple staff, but usually for medication observations or in the clinic. Staff interviewed report that they are assigned a primary caseload and also rotate contact with other members in order to meet fidelity.	<ul style="list-style-type: none"> Brainstorm opportunities to expand the types of services delivered through the team, based on member goals and needs, when there is contact with members. As new staff are hired and further trained to fulfill specialty positions, a more diverse service mix may be delivered through the team.
H3	Program Meeting	1 – 5 (5)	<p>The ACT team meets four days a week for their morning meeting. On Monday, Tuesday, Wednesday, and Thursday the ACT team meets from 10:30 am-12:00 pm. Monday-Wednesday all members are briefly discussed. On Thursday, the morning meeting ends later due to staff engaging in more in-depth discussion of member status and needs. The CC reported that the Psychiatrist and the two Nurses attend three out of the four days due to their flex schedules.</p> <p>The morning meeting observed was from 10:15-11:55 a.m. (1 hour, 40 minutes). During this meeting, the CC led the meeting, and provided most updates. The majority of the meeting was focused on medication observations and medication doses; there was limited discussion regarding member needs and potential interventions. Though staff provided some</p>	<ul style="list-style-type: none"> When the full team is present for the meeting, and as vacancies are filled, ensure members receive support through the entire team and not primarily through one Case Manager (CM). Optimally, multiple staff would be aware of member status, with recent contacts or support discussed in order to update the full team. Some teams elect to review members by area of specialty which emphasizes the specialty positions and the integral roles they play.

Item #	Item	Rating	Rating Rationale	Recommendations
			updates, it appeared they primarily reported on their assigned member caseload or those with whom there was recent contact for medication services, and other issues were addressed as ancillary events.	
H4	Practicing ACT Leader	1 – 5 (3)	<p>Based on a review of agency documentation, the ACT Clinical Coordinator (CC) provides direct care to members an average of 7.5 hours a week, totaling 18.95% of his time for direct contact with members. These contacts included medication observations, home visits, hospital visits, and other community-based services. Although not factored in this area, the CC also documented contact with member informal support systems. The CC reported that he is able to do more direct service due to his Clinical Director (CD) taking over some of the administrative duties. The provider is also monitoring direct service time as part of a broader approach to monitoring fidelity measures using the agency electronic health record.</p> <p>Although the CC routinely provides services, it appears the actual direct face-to-face member services account for less than 25% of his time.</p>	<ul style="list-style-type: none"> • 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. • CC needs to continue efforts to increase direct member services, with a goal of 50% of his total time, in order to remain in touch with the members served by the team and model appropriate clinical interventions.
H5	Continuity of Staffing	1 – 5 (4)	<p>Over a two year period nine staff left the team, resulting in a 35% turnover rate.</p> <p>At time of review, there were three vacancies; in addition, one staff was on extended leave, and one staff recently returned to part-time 50% duty after an extended leave.</p>	<ul style="list-style-type: none"> • If not in place, the agency should consider using staff satisfaction surveys and exit interviews to determine factors contributing to staff retention and turnover.
H6	Staff Capacity	1 – 5 (3)	<p>There were 32 total vacancies over the 12-month review timeframe, including change in CC, two staff on extended leave, and the addition of a second Nurse position. The vacancy rate for the 12</p>	<ul style="list-style-type: none"> • See recommendation for H5. • Recruit qualified staff to fill vacant positions, including both SAS and the PSS position.

Item #	Item	Rating	Rating Rationale	Recommendations
			months prior to review was 79%; three positions remain vacant since August, 2015.	
H7	Psychiatrist on Team	1 – 5 (3)	The teams Psychiatrist was on extended leave from June through September, He recently returned part time and is assigned 100% to the ACT team, currently at .5 full-time equivalents (FTE). The Psychiatrist provides some services to members who are not on the ACT team, but not a significant portion of his time is spent in that capacity. Staff report the Psychiatrist is accessible and attends team morning meetings three out of the four days.	<ul style="list-style-type: none"> The Psychiatrist was on leave during the review period, but has since returned to the team on a part-time basis; the program should revisit this area at a future date, if necessary, to ensure at least one FTE Psychiatrist works with the program.
H8	Nurse on Team	1 – 5 (4)	The ACT team currently has two full-time Nurses; one is the lead Nurse at the clinic who estimated that she spends approximately 15% of her time with duties in that capacity. Although both Nurses work a flex schedule, staff report they are accessible, attend morning meetings, provide injectable medications, health monitoring, PCP coordination, and physical and behavioral health support and education to all members of the team. One Nurse has been on the team for 11 years and co-facilitates the weekly Substance Abuse group. Staff interviews and documentation found support that the Nurses do provide some services in the community.	<ul style="list-style-type: none"> Consider including the Nurses in more community-based activities, such as community-based medication observation or related activities. Some members go to the clinic for medi-set services through the team Nurses, but also receive medication observation in the community.
H9	Substance Abuse Specialist on Team	1 – 5 (1)	The team currently has no Substance Abuse Specialist (SAS). One position has been vacant since October, 2014 and the second SAS left the team in May, 2015.	<ul style="list-style-type: none"> The team should have at least two staff members on the team with at least one year of training or clinical experience in substance abuse treatment, per 100 members. Continue efforts to recruit experienced staff for the SAS position.
H10	Vocational Specialist on Team	1 – 5 (3)	The team currently has both positions of Employment Specialist (ES) and Rehabilitation	<ul style="list-style-type: none"> Fully integrated ACT teams include vocational services to assist members to

Item #	Item	Rating	Rating Rationale	Recommendations
			<p>Specialist (RS) filled. The CC reported that the ES joined the team on August 23, 2015 and provided an updated resume which listed past experience in vocational services as components of her prior positions. The ES reported during interview that she has met with the employment staff from the Regional Behavioral Health Authority (RBHA) once since hired but has not attended any specialized training. The RS has been in the role for over a year, and also has met with RBHA vocational department staff for guidance.</p> <p>The CC reported some members need more support, and the team sends referrals to employment support providers, including some members with a co-located provider within the agency or other work adjustment training (WAT) programs. During observed morning team meeting, members with employment goals or those currently working were discussed, and in most cases the ES did not provide any feedback or recommendations.</p> <p>Both vocational staff do have some vocational experience; however, it is not clear if the identified staff received education or sufficient training to successfully fill the role of vocational specialists, and it does not appear the team directly provides individual employment services focused on assisting members in job searches and sustaining employment in integrated work settings.</p>	<p>find and keep jobs in integrated work settings. The team should identify potential barriers to directly providing vocational services versus referring to outside providers.</p> <ul style="list-style-type: none"> 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 population served (i.e., adults diagnosed with a serious mental illness).
H11	Program Size	1 – 5 (4)	The team currently has three open positions, and eight full-time staff (excluding administrative support staff). The team Psychiatrist has recently returned part-time, totaling 8.5 staff (excluding any staff on extended leave); making a less than	<ul style="list-style-type: none"> The agency needs to fill open positions to ensure team provides necessary staffing diversity and coverage.

Item #	Item	Rating	Rating Rationale	Recommendations
			adequate staff to serve the 93 members.	
O1	Explicit Admission Criteria	1 – 5 (4)	The CC provided the ACT admission criteria, used to screen potential members for appropriateness for ACT services. Though the ACT population is clearly defined, staff report that the team has experienced administrative pressure to accept members that the staff does not feel are appropriate for the team.	<ul style="list-style-type: none"> Continue to carefully screen members for ACT appropriateness prior to admission. If members are not appropriate for ACT services, work with referral sources to identify and facilitate admission to a more appropriate level of care whenever possible. Empower ACT staff to provide input regarding potential new admissions; the ACT team should make the final determination and not bow to organizational pressure.
O2	Intake Rate	1 – 5 (5)	The team maintains a low growth rate to maintain stability of service delivery. The team's highest monthly intake rate in the past six months was in April, 2015, with five admissions. There was one admission each month for May and September, 2015, with no admissions June through August, 2015.	
O3	Full Responsibility for Treatment Services	1 – 5 (3)	In addition to case management, the ACT team provides two additional services and refers externally to others. The ACT team provides psychiatric services and housing support. ACT staff report referring to network providers for supported employment programs, general counseling and individualized substance abuse treatment. CC and staff report that the team RS and ES do provide engagement and some light job development support such as resume writing. However, some members need more support, and the team sends referrals to employment support providers, including some members with a co-located provider within the agency or other work adjustment training (WAT) programs. The CC reported if members want to meet with a licensed	<ul style="list-style-type: none"> Prior to referring a member to an external provider, review what that program will offer that the ACT team is not expected to provide. For example, if a person wants to work, the team vocational staff should assist in the job search. Fully integrated ACT teams include vocational services to assist members to find and keep jobs in integrated work settings. The agency should continue to review training and supervision options to ensure staff designated with a specialty area receive monitoring, support, and supervision specific to their role. Explore opportunities for professional development for staff in specialty ACT positions. The

Item #	Item	Rating	Rating Rationale	Recommendations
			<p>therapist, the team refers out, but they attempt to provide supportive therapy when they make contact with members. It does not appear that counseling/psychotherapy and substance abuse treatment are provided through the team, so they refer to other providers (e.g., 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.</p>	<p>agency and RBHA should solicit input from ACT staff to identify barriers to the ACT team directly providing the full spectrum of services, including vocational support and SA treatment, to the majority of members who receive support in those service areas.</p>
O4	Responsibility for Crisis Services	1 – 5 (5)	<p>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. Staff report that a list of team contact numbers is provided to members at time of intake. The CC reports he is available to support staff 24 hours-a-day, seven days-a-week. Some members report they are not sure who to call during a crisis.</p>	<ul style="list-style-type: none"> Update the team phone contact lists to offer to members each time staff join or leave the team. Ensure all members, and their informal supports are aware of the team on-call contact number.
O5	Responsibility for Hospital Admissions	1 – 5 (4)	<p>The team reports they work with members in an effort to divert from hospitalization if other supports can be provided and are involved in most hospital admissions, but some members self-admit or are petitioned by their family for inpatient evaluation without informing the team. Per data and CC interview, staff was involved in seven out of last ten hospital admissions.</p>	<ul style="list-style-type: none"> Maintain consistent contact with all members and their involved support systems (see recommendation for S6), which may allow the team opportunities to discuss the pros and cons of informing the team of issues that might lead to hospitalization, to potentially divert, or to assist in a hospital admission, if the need

Item #	Item	Rating	Rating Rationale	Recommendations
				should arise.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	Per data and CC interview, the team was involved in all ten of the most recent hospital discharges, and is generally involved in all discharges. The team reports they attend or request discharge staffings, as well as visit members in the hospital within 72 hours of admission, and every three days thereafter, including the weekends. The team maintains regular contact with hospital Social Worker for discharge planning. Following discharge, the team maintains five day follow-up with members, and coordinates an appointment with the Psychiatrist within 72 hours of discharge.	
O7	Time-unlimited Services	1 – 5 (5)	In the past 12-month period prior to review, one member graduated (i.e., need for services was reduced), and the CC estimates three ready to graduate for the next 12 months.	
S1	Community-based Services	1 – 5 (2)	Per 10 member records randomly selected for review, the ratio of services delivered in the community verses those delivered in the office ranged from 0-88%, with a median of 33% face-to-face contacts in the community, with five members receiving 35% or less of contacts in the community.	<ul style="list-style-type: none"> • The agency and CC need to review staff duties and activities to assure that staff is supported to spend at least 80% of total service time in the community. Work with ACT team staff to brainstorm ideas to increase community-based services. Supportive housing services, assisting with employment goals, peer support services, individual SA treatment, and other skill development activities should occur in the community rather than the clinic whenever possible. • The team Psychiatrist and Nurses should consider increasing community-based services.
S2	No Drop-out Policy	1 – 5 (5)	The team retained 98% of their members in the past 12 months. The CC reported that one member elected to change service level and	

Item #	Item	Rating	Rating Rationale	Recommendations
			<p>moved to a supportive team, and one member moved out of state without referral.</p>	
S3	Assertive Engagement Mechanisms	1 – 5 (5)	<p>The team reported that there is a <i>Closure for Lack of Engagement Desktop Procedure</i> to follow when members need outreach. The procedure outlines outreach activities that should occur over a six to 12-month timeframe, and notes that if contact is made, but the member declines to participate in treatment and does not attend an appointment with the Behavioral Health Medical Practitioner (BHMP) a minimum of every 90 days, the member’s status is discussed with the clinical team prior to closure. Team uses engagement and outreach strategies such as medication observations, home visits, hospital visits, coordination with guardians, payee’s services, and street outreach in areas members are known to frequent to keep members engaged in treatment.</p> <p>There is evidence that a member not engaging in services was left open for an extended time due to the Psychiatrist’s recommendation, though over the timeframe reviewed, it did not appear that outreach activity occurred as outlined in the desktop procedure</p>	<ul style="list-style-type: none"> The team needs to make sure that outreach attempts are documented in members’ chart as outlined in the agency desktop procedure.
S4	Intensity of Services	1 – 5 (4)	<p>The median intensity of service was 91 minutes a week based on review of ten member records, with four members under 50 minutes of contact on average per week, but six members receiving 91 minutes or more of direct services on average. Although there is a high number of minutes for some members, encounter notes in the records were mainly focused on medication monitoring, and medication administering (i.e., injections medi-sets) with limited content regarding other direct services. Staff document contacts with</p>	<ul style="list-style-type: none"> As the team becomes fully-staffed, refrain from providing services in traditional case management form. The ACT model promotes psychiatric stability by providing relevant services to members in an intense manner. As the team begins to provide a wider range of services directly, rather than relying on other providers for some services (e.g., for SA counseling, vocational

Item #	Item	Rating	Rating Rationale	Recommendations
			members in varying detail; some staff document a variety of types of services delivered, and other staff focus primarily on one or two areas (e.g., medication observation and brief assessment of the residence).	supports), the team may be able to increase services in attempt to balance the intensity of services across members. See recommendation for O3 for additional information.
S5	Frequency of Contact	1 – 5 (3)	Per ten member records randomly reviewed, the team delivered an average of three face-to-face contacts, per member, per week. Although two members received more than ten contacts on average per week, five members received an average of less than three face-to-face contacts per week. Members confirm that they see their “primary” case manager once or twice weekly. Staff and members interviewed confirmed that the shortage of staff on the team has directly impacted the frequency of contact with members.	<ul style="list-style-type: none"> Establish a coverage schedule that strategically organizes staff in a rotation that maximizes member contacts, working toward the goal of at least four contacts per week, per member.
S6	Work with Support System	1 – 5 (2)	<p>During interviews, staff had difficulty estimating the average monthly contact with informal supports, noting that informal support involvement varies from member to member, and that some members do not have informal supports. The CC reported about 75% of members had informal supports, and for about 40% of those members the team was in contact with those informal supports at least monthly. Based on record review, there is less than one contact per month for each member.</p> <p>During morning meeting observation, there was evidence of recent team contact with informal supports for about ten members out of 93. It is estimated the team maintains .5 contacts per month per member.</p>	<ul style="list-style-type: none"> The team needs to encourage members to identify external supports and discuss with them the benefits of involving supports in treatments. These supports may include family, landlords, employers, or anyone else with whom members have consistent contact. Establishing communication may allow the team to provide education regarding serious mental illness, and to advocate for members. Once a member identifies a support, the team should maintain contact consistently to support members, who are doing well, as well as to proactively identify and address potential issues if necessary.
S7	Individualized Substance Abuse	1 – 5 (2)	The team does not currently provide regular, direct substance abuse treatment to members	<ul style="list-style-type: none"> Recruit and fill both SAS vacancies as soon as possible with a focus on staff that is able

Item #	Item	Rating	Rating Rationale	Recommendations
	Treatment		with co-occurring disorders. The staff indicated that members can discuss concerns with team, and some notes did indicate staff intermittently addresses SA issues with members; however there is no Substance Abuse Specialist on the team at time of review.	<p>to fulfill the need for individualized substance abuse treatment on the team.</p> <ul style="list-style-type: none"> The program should ensure staff are trained and receive supervision to provide substance abuse treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	At time of review, both SAS positions are vacant. One Nurse has been on the team for 11 years and co-facilitates the Substance Abuse groups, usually with a team SAS when the positions are filled. The current RS was formerly the SAS on the team, and co-facilitates some groups with the Nurse. The Nurse reported during interview that she facilitates these groups weekly for one hour, and the group is open to the entire clinic. Out of 44 members of the ACT team who are identified as co-occurring, it is estimated that about six or seven attend SA group weekly, averaging 15 % of members with co-occurring disorder attend the group at least once a month.	<ul style="list-style-type: none"> If not already established, the RBHA should ensure appropriate training and education is provided to ensure the ACT teams are following an established, stage-wise curriculum, such as Integrated Dual Disorders Treatment. The team should continue to engage members 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)	<p>The team offers an SA treatment group, and although they sometimes follow a curriculum, the nature of the groups tends to focus on relapse due to increase in symptoms, stressors, how to support members to not use substances, and how mental health and SA interact. Based on notes, the SA group includes discussion of health and wellness, physical health, and exercise.</p> <p>Due to the lack of SAS staff on the team, the reviewers interviewed the Nurse who co-facilitates the SA group . The Nurse reported that the team is familiar with the Co-Occurring Disorder model. During interview the Nurse used stages of change language and reported that she and the team continue to use motivational interviewing</p>	<ul style="list-style-type: none"> 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. Ensure the team language aligns with a recovery approach (e.g., not using “clean” and “dirty”). The team should directly provide SA treatment to the majority of members who

Item #	Item	Rating	Rating Rationale	Recommendations
			<p>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.</p> <p>Three members who attend the co-occurring group were interviewed. The members stated they feel they can be honest about their substance use, that staff are supportive and do not shame them for their substance use or if they relapse, and although they are aware that staff do not approve of their substance use, they continue to be supportive and encourage reduction.</p> <p>Treatment plans incorporate stage of change language. The team rarely uses detox, usually only when medically necessary, but may facilitate inpatient treatment in some cases even if detoxification is not medically necessary (e.g., if a person uses methamphetamine). The team occasionally refers members to Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) and report they offer to attend with members. Some staff are aware of the potential for mixed messages (i.e., to not take medications) in some AA groups. Due to no SAS staff it does not appear the team is in a position to offer SA treatment directly, and as a result refers members out to other agencies.</p>	<p>receive that type of support.</p>
S10	Role of Consumers on Treatment Team	1 – 5 (1)	<p>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.</p> <p>This position has been vacant since August, 2015.</p>	<ul style="list-style-type: none"> Recruit and hire an individual with a lived experience of mental illness to fill the open PSS position on the team.

Item #	Item	Rating	Rating Rationale	Recommendations
Total Score:		3.54		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	3
8. Nurse on Team	1-5	4
9. Substance Abuse Specialist on Team	1-5	1
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	4
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	4
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	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	2
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		3.54
Highest Possible Score		5