ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: September 22, 2015

To: Elizabeth daCosta, F-ACT Clinical Coordinator

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ADHS Fidelity Reviewers

Method

On August 31, and September 1, 2015 T.J. Eggsware and Jeni Serrano completed a review of the Community Bridges, Inc. (CBI) 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.

Community Bridges, Inc. has a 31-year history of providing comprehensive, medically-integrated behavioral health programs which include prevention, education and treatment services. The CBI Forensic ACT (F-ACT) team began providing services August 1, 2014. The team functions out of two offices and in the community. The Psychiatrist and Nurses are located in the Central City location, where members go for psychiatric appointments, substance abuse treatment groups, and some in-office nursing services. Other F-ACT staff work out of an office located in Central Phoenix near other social service agencies.

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

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

- Observation of the F-ACT team meeting on August 31, 2015
- Individual interview with Clinical Coordinator (i.e., Team Leader)
- Individual interviews with a Substance Abuse Specialist (SAS), Peer Support Specialist (PSS), and Employment Specialist (ES)
- Group interview with 11 members served by the team
- Review of ten member records using the agency's electronic health records system
- Review of *F-ACT Admission Screening* form, and *ACT Exit Screening Tool* implemented by the Regional Behavioral Health Authority (RBHA)
- Review of the team Process for "F-ACT Patients into Transition Point and Ongoing Coordination"
- Brief review of group treatment manuals
- Review of the team staffing schedule

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:

- Members interviewed report staff are supportive and offer hope; this was evident in staff interviews and observations. For example, during the morning meeting staff celebrated member progress successes, and the Clinical Coordinator (CC) frequently acknowledged the team and staff. Staff interviewed gave examples of how they seek to support individuals with legal challenges, including the belief that members with legal issues can be gainfully employed. Staff and members cite examples of staff providing individualized services, with a flexible approach; someone is always available to support members. The team celebrates successes such as reduced jail sentences due to F-ACT staff intervention, services, and support to members. There was evidence staff are open to sharing lived experiences with members when appropriate; members confirmed this openness was beneficial.
- Although the team maintains two office spaces, most staff appear to spend the majority of their time outside of the office setting, with resources (e.g., smartphones, some team cars, laptops with internet access) to maintain productivity in the field or wherever tasks of the day might lead. For example, during the review, staff seemed comfortable using their laptops during the team meeting, but the computers did not appear to be a distraction from member-focused discussions and team planning, but rather allowed staff to act immediately on some plans using their computers. Additionally, some staff transported members to another CBI location for interviews, and, rather than having downtime, staff diligently utilized their computers in the lobby space while members met with the review team.
- The F-ACT team has two Nurses. Staff and members gave multiple examples of how the Nurses are integral to the team, citing they are always available, act as liaisons between members and other staff, proactively assist members, and are willing to adapt to meet the needs of the members. During the morning meeting, the Nurses discussed member benefits, court attendance, and other services not traditionally associated with a nursing role (i.e., focused only on medication education, injections, labs or coordination services).
- The program offers individual counseling, group substance abuse treatment, and appears to generally use a harm reduction approach when addressing substance abuse issues.
- The F-ACT team works to build relationships with formal supports, such as Probation or Parole Officers, by participating in court proceedings, when applicable, and by educating correctional system representatives about services available through the F-ACT team. Members interviewed cite the value of these types of working relationships and team approach to service delivery.

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

- Ensure services are primarily provided through the F-ACT team rather than relying on outside providers or other CBI programs.
    - The team sometimes relies on other CBI programs; at least one appears to provide support that overlaps with some ACT service areas. CBI has a facility called Access Point, and a sister program called Transition Point, that provide crisis stabilization, bridge

prescriptions and psychiatric consultation. The agency brochure describes Transition Point as a medically-monitored, short-term crisis residential setting with stays of three to five days, where medication stabilization and hospital step-down support is offered. F-ACT members can be housed in Transition Point facilities temporarily following release from jail or prison while staff attempt to assist members to apply for other housing, securing benefits, obtaining identification. However, staff reported using the facility because of limited availability of housing for members served through the F-ACT team. Based on interviews and record review, F-ACT members may have longer stays than other members not associated with F-ACT services with stays lasting up to weeks depending on the member's situation. Although voluntary, some members report they were strongly encouraged to go to the facility. The Transition Point staff provide services in the residence, which appear to overlap with housing support services, a primary function of ACT services. An informal protocol was provided for review, but it focuses primarily on admission, Psychiatrist services through F-ACT, and the process for discharging F-ACT members from Transition Point, but not other in home supports that should be provided through the F-ACT team.

  - Continue efforts to educate correctional system representatives of F-ACT services available to members in an effort to deter court mandated referrals to brokered services that should be provided through the F-ACT team. Ensure member choice is supported if referring for services; review service options with members prior to referral or team recommendations to the court.

- The ACT team should increase the intensity and frequency of services to members.
- Continue to engage members with substance use challenges to participate in individual and group treatment. The team should implement a recognized integrated dual diagnosis treatment to standardize the team approach when working with members with substance use challenges.
- Continue to engage informal support networks of members; discuss how the team can support them to assist members. For example, how the team can work with informal supports to aid a member during a hospital admission, or potentially divert it altogether.
- If a member is assessed by the team for hospital admission, ensure the team Psychiatrist and Nurse are involved as a first line of support to members. Through the team, other interventions or supports may be identified to potentially divert hospital admissions. Continue to educate inpatient staff about the F-ACT team, including contact information and team structure.
- The program should review the pros and cons of having one central office location. When asked how the program could improve services, some members and staff cited the potential benefits of a central office (e.g., a place to make contact with staff, to hold groups, and another place to socialize with others). Although a central office space might offer some benefits, the program needs to weigh the importance of delivering most services to members in the community; ACT should not function primarily as an office-based program. The team should strive to provide a high level of community-based services versus services delivered in F-ACT offices or other CBI facilities.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team serves 83 members with 11 staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of 8:1.	
H2	Team Approach	1 – 5 (4)	Although primary staff are assigned to each member, the team appears to primarily function with a shared caseload and members are served by the full team. This approach was evident during the morning meeting observation, with multiple staff aware of the status of members, involvement of multiple staff in most discussions, as well as cross-training or support by specialists (e.g., Housing Specialist discussed housing prioritization tools, updates to the form, and resources for pregnant women). The CC estimates 90% of members see more than one staff over a two-week period; however, based on ten records reviewed, 80% of members met with more than one staff over a two-week period.	• Ensure the majority of members have contact with more than one staff over a two-week period, and that all services are documented. Ensure contact is maintained with members who are incarcerated, and if outreach occurs, is documented, for members not in regular contact with the team.
H3	Program Meeting	1 – 5 (4)	The team (excluding the Psychiatrist) meets at the Central Phoenix location three times a week and the full team (including the Psychiatrist) meets at the Central City location one day a week. Based on observation, the Nurses act as liaison between other team members and the Psychiatrist during meetings when the Psychiatrist is not present. There is evidence this team communicates effectively, using smartphones, texts, email communication, and verbally. Other team members attend most meetings, unless not scheduled to work, if in court, etc. During the morning meeting, the CC provided feedback and positive accolades to staff; successes	• Optimally, all members are discussed at each team meeting. The structure and discussion of members during the morning meeting should be closely monitored. If there are barriers to team communication and coordination via other means, the provider should assess whether the scheduled morning meeting time should be extended, so all members are discussed at each meeting. • Some teams elect to have the Psychiatrist at all daily meetings; continue to evaluate program and member needs to determine if the Psychiatrist should attend daily

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			were discussed, including members released from incarcerated settings, and reduced sentences due to clinical team intervention or support. The nature of discussion focused on strengths of members and supports, with a recovery-oriented, proactive approach to services. Per staff report, the team tries to discuss all members at each meeting, and most of the time the team goes through the entire roster, but sometimes there is not enough time to discuss all members. The meeting observed was scheduled for an hour but lasted for about an hour and forty minutes, but it appeared all members were discussed.	meetings more than once a week.
H4	Practicing ACT Leader	1 – 5 (3)	The CC provides services routinely based on report and documentation, as well as provides backup to other staff. The CC estimates her time in the field at around 50%. Documentation of CC services indicates approximately 21% of her time is spent providing direct member services.	• CC should continue to provide community-based services; increase direct services (i.e., face-to-face contact with members) to 50% 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)	Three staff left the team in the previous year, resulting in a 25% turnover rate.	• If not in place, the agency should consider using staff satisfaction surveys to determine what is working to retain staff as well as staff exit interviews/surveys to determine what contributes to staff turnover.
H6	Staff Capacity	1 – 5 (4)	F-ACT team operated at 90% staff capacity during the review timeframe.	• See recommendation for H5.
H7	Psychiatrist on Team	1 – 5 (5)	There is one full-time Psychiatrist assigned directly to the 83-member program. The Psychiatrist has no other administrative duties outside of the team, and does not regularly see members of other CBI programs. Most members report they primarily meet with the Psychiatrist in the office.	

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			The Psychiatrist does not attend all team meetings, but staff and members report she is accessible and available to members.	
H8	Nurse on Team	1 – 5 (5)	The team has two full-time Nurses for the 83-member program. Staff and members report the Nurses are accessible and available to members. Based on observation and documentation, the Nurses provide traditional nursing services such as medication observation, medication education and monitoring, and serving as liaison with medical providers. They also provide non-traditional nursing services such as attending court, home visit contact, assisting with benefits, a variety of other community-based supports to members, and also carry a primary caseload. Based on observation, as well as staff and member report, the Nurses on the team provide services that are flexible and adapted to meet the needs of the members served.	• The RBHA should consider engaging the Nurses on the F-ACT team to provide education and guidance to ACT Nurses on other teams if they are struggling with adjusting to the role of ACT Nurse.
H9	Substance Abuse Specialist on Team	1 – 5 (4)	The team has two staff in the position of SAS; one staff is a Licensed Associate Substance Abuse Counselor (LASAC), with the team since July, 2015, and the other is a Licensed Associate Counselor (LAC), with the team since March, 2015. The first SAS is licensed in substance abuse counseling; however, the second SAS is not licensed in the specific area and does not have at least one year training/experience working with the SMI population; prior experience was working with adolescents.	• Ensure SAS staff receive supervision and training related to treatment of adults with co-occurring issues.
H10	Vocational Specialist on Team	1 – 5 (4)	The team has two vocational service staff; the ES and Rehabilitation Specialist (RS) started with the team at program inception on August 1, 2014. It appears the staff assist members in exploring employment options, but not with all phases of	• Ensure both vocational support staff receive supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings.

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			the employment search. It does not appear both staff received training or have supervised experience in vocational services that enable members to find and keep jobs in integrated work settings.	• Attempt to identify potential system barriers to the F-ACT team directly proving vocational support services, such as job development, follow along supports to employed members, etc. • The Dartmouth Psychiatric Research Center (PRC) has resources to help Employment Specialists who work with people with criminal histories.
H11	Program Size	1 – 5 (5)	The team is of appropriate size with 11 staff (excluding administrative support staff).	
O1	Explicit Admission Criteria	1 – 5 (5)	The F-ACT team actively recruits a defined population, including referrals via jail release planners. Additionally, if another CBI program serves a member that may benefit from F-ACT, then the team collaborates to reach out to the clinical teams for those members to consider referral to the F-ACT team. Members are screened for F-ACT using a written criteria developed by the RBHA. Once referred, F-ACT staff conduct screenings; the team makes the final determination regarding admissions to the team.	
O2	Intake Rate	1 – 5 (4)	The peak intake rate in the six months prior to review was nine members in February, 2015. For March – July, 2015 member admissions ranged from four to eight per month. There is a written criteria, the *F-ACT Admission Screening*, developed by the RBHA.	• The team was established August 1, 2014. Once the team has operated for an extended period of time, and F-ACT team meets full capacity, the monthly intake rate will likely stabilize.
O3	Full Responsibility for Treatment Services	1 – 5 (4)	In addition to case management, the F-ACT team directly provides psychiatric services and medication management (3 of 5 services). Although staff are assigned primary caseloads, members are aware of a spectrum of services available through the team. Members are aware of staff specialty positions and some identify multiple	• Formalize agency policy regarding F-ACT services when members are in the Access Point and Transition Point facilities. • The agency should continue to review training and supervision options to ensure staff designated with a specialty area receive monitoring, support, and

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			staff and their specialty area on the team. Counseling is provided through the team to most members, unless they are court mandated to receive specialized treatment (e.g., Sexual Offender treatment, Dialectical Behavior Therapy). The F-ACT team offers individual and group substance abuse treatment, and most members who receive support in the area receive the service through the team. As part of their treatment approach to address substance abuse issues, the team refers members to Consumer Operated Service providers for socialization and activities. This is not a service the team would be able to replicate under the ACT model, and the primary program where members are referred is also known to serve individuals with legal issues. It does not appear the F-ACT team provides 90% or more of housing and employment/rehabilitative services directly. The FACT team explores multiple options for housing, use housing prioritization screening tools, and offer support to members in the community. However, due to reported lack of housing availability for the population served, the team utilizes other CBI programs for housing support (e.g., Access and Transition Points). Most of the members interviewed received support in these locations during their course of treatment with the F-ACT team. Some member records reviewed reflected a high level of service from CBI Transition Point programs. Transition Point supports are accessed during periods of crisis and may result in extended lengths of stay (more than three to five days) for some F-ACT members. Some members temporarily reside in another CBI facility	supervision specific to their role. See recommendation for H10 regarding training of vocational staff. • Optimally the team should directly provide a spectrum of services, including vocational and housing supports, 90% or more of the time to members who receive support in those service areas. • The agency and RBHA should discuss the pros and cons of developing alternative short term housing for F-ACT members where the F-ACT team is the primary service provider.

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			where non-F-ACT staff provide some in home service. As a result, it appears external housing supports are provided to approximately 17% of all F-ACT members. The program refers members to external employment support agencies, with approximately 45% of members who receive support in the area served by brokered employment service agencies.	
O4	Responsibility for Crisis Services	1 – 5 (5)	The F-ACT team provides 24-hour coverage; on-call duties are rotated between five Case Manager (CM) staff every four days. On-call contacts with members are discussed during the morning meeting. For example, over the month of August, staff coverage includes weekend hours, with at least one staff 7:00AM through 7:00PM and two staff overlapping coverage 11:00AM through 3:00PM. One of the team Nurses has regular hours on Sunday. The F-ACT team has scheduled overlapping coverage of 7:00AM through 7:00PM on weekdays. If the local crisis phone line is contacted, they contact the CC. A notice in the electronic health record alerts the crisis line staff of member assignment to the F-ACT. A team Nurse is always on-call, and staff can reach out to those supports for assistance. Members confirm F-ACT staff are available to assist when needed. Per staff report, CBI has infrastructure in place to support members in crisis; if an individual has an increase in symptoms, two F-ACT staff can meet with the member in the community. The F-ACT team can seek support through CBI Access to Care Staff, with Emergency Medical Technicians, but per report this is rarely necessary. As noted above, the F-ACT also has access to CBI Access and	• If members are placed in other CBI programs, ensure protocols or policies are in place to outline how the F-ACT staff will take a primary role to provide support.

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			Transition Point services.	
O5	Responsibility for Hospital Admissions	1 – 5 (3)	F-ACT staff report the team attempts to divert hospital admissions when possible and cite the infrastructure of CBI aids in this effort. For example, the F-ACT can refer members to CBI Access and Transition Point to assist with monitoring medications, and to help members get through a crisis. If staff identify members with concerns in the community, the F-ACT team will file petitions for Court Ordered Evaluation (COE), but also give examples of staff efforts to support members in the community (e.g., on-call contact with a member at a recurring frequency to bridge services until the member could meet with the team Psychiatrist). Staff estimate they are involved in 80% of hospital admissions, with some members self-admitting or petitioned for COE by police or family. Based on review of recent admissions, it appears the F-ACT team is involved in slightly less than 64% of admissions.	• Ensure consistent contact is maintained with all members served, which may result in the identification of issues or concerns that could lead to hospitalization. • Continue to work with each member and their support network to review how the team can support them to potentially divert, or to assist in a hospital admission, if the need should arise. • If the team assesses a member for potential hospital admission, ensure the team Psychiatrist and Nurse are involved as a first line of support. Through the team, other interventions may be identified to potentially divert hospital admissions. • Continue to educate inpatient staff about the F-ACT team, including contact information and team structure.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	Staff report they are involved in all hospital discharges. Members who recently discharged were discussed in the morning meeting, and the CC reports staff attempt to see inpatient members every 72 hours, coordinate with inpatient Social Workers, facilitate doctor-to-doctor consultations, and ensure all applications for housing are completed before members are discharge ready. Staff report the team attempts to involve family supports in discharge planning. After discharge, F-ACT supports include increased staff contact with members within 24 hours of discharge, face-to-	

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			face contact for five days, and medication observation.	
O7	Time-unlimited Services	1 – 5 (5)	All members are served on a time-unlimited basis, with fewer than 5% expected to graduate annually. There were no member graduations since program inception, and no potential member step-downs were identified.	
S1	Community-based Services	1 – 5 (4)	ACT team staff are mobile and have access to technology and resources to support their provision of community-based services to members. For example, staff are provided laptops with Wi-Fi connectivity and smart phones. Some staff on the team have company vehicles full-time, and there is a shared car for those who are not assigned a company vehicle. Based on observations, staff take every opportunity to maximize time when not providing direct services, for example using laptops to document activity and coordinate services. Although the team maintains office space in two locations, some staff reportedly spend most time in the field. The Psychiatrist appears to provide primarily office-based services, but goes into the community on occasion. The Nurses and SAS staff have a mix of office-based and community-based activities. Some F-ACT staff activities occur at other CBI facilities; other CBI facilities were considered office-based for the purposes of this review. Staff estimates ranged from 90-95% of time spent in the field, but based on review of ten member records, approximately 60% of services are community-based.	• Continue efforts to increase the amount of direct member services in the community. The agency should work with program staff to brainstorm ideas to increase community-based services and ensure those are documented accurately.

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S2	No Drop-out Policy	1 – 5 (5)	Based on data provided, one member could not be located and was closed. Some members closed for other reasons not factored in this area (e.g., two other members left the geographic area with referral, three closed due to long-term prison sentences). Based on report, more than 98% of the F-ACT team caseload was retained over the 12-month period.	
S3	Assertive Engagement Mechanisms	1 – 5 (5)	The F-ACT team uses a variety of outreach and engagement mechanisms, including coordination with Probation or Parole Officers (PO), attending court with members, and coordination with payee services. One of the team offices is located in an area near other social service agencies where members can make contact with team supports. The location of the facility is one factor positively affecting engagement, but the team demonstrates other approaches to outreach, member engagement and advocacy that members find helpful. For example, members interviewed reported F-ACT staff assist them to address legal challenges, sometimes advocating for members when interacting with POs. This was demonstrated in the morning meeting; the team discussed going to court on a member's behalf, and writing a letter to present to the PO to advocate for one of the members.	
S4	Intensity of Services	1 – 5 (3)	The median intensity of service per member was 58 minutes a week based on review of ten member records.	• Increase the intensity of services to members, optimally averaging two hours a week or more of face-to-face contact for each member. Explore what actions the team can take resulting in higher service intensity per member. Ensure all members are primarily served through the F-ACT

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				team rather than external providers or staff at other CBI programs such as Transition Point.
S5	Frequency of Contact	1 – 5 (3)	The median weekly face-to-face contact for ten members was 2.4 based on record review. Staff estimate a high frequency of contact with some members, especially those who receive medication observation services. Staff report they make efforts to track who the team made contact with in order to target their outreach efforts.	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member. Ensure outreach occurs for members not in contact with the team, as well as maintaining contact with incarcerated members. • See the recommendation above regarding services through the team over external providers or other CBI programs.
S6	Work with Support System	1 – 5 (3)	The team discussed contacts and plans to outreach various informal member supports during the morning meeting; these included mothers, fathers, sisters, landlords, and significant others. The staff and informal support interactions included staffings with family at inpatient settings, and contact during home visits. There was evidence of team contact with informal supports for about 15 members based on morning meeting observation. During interviews, staff had difficulty estimating the average monthly contact with informal supports, noting that informal support involvement varied from member to member. However, the CC estimated about 50% of members had supports, with the team maintaining about weekly contact with those supports. There was an average of .5 contacts documented in the ten member records reviewed. Based on data provided, it is estimated the team averages slightly more than one contact per month with informal	• Continue to ensure F-ACT staff review with members the potential benefits of engagement with informal supports, and attempt to secure a Release of Information (ROI) allowing staff to contact identified supports. • If a member declines to allow staff to make contact with informal supports this should be documented in the record. However, staff can generally receive information from informal supports and may be able to share limited data with known supports in some situations. If necessary, review confidentiality guidelines when developing an agency plan to engage informal supports.

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			supports across all members on the team.	
S7	Individualized Substance Abuse Treatment	1 – 5 (4)	The team reports 72 of the 83 members served by the team face co-occurring challenges. The team SASs offer formal individualized substance abuse treatment; per report some members receive hour long individual substance abuse treatment weekly. This frequency and duration is consistent with information in some member records reviewed. Approximately 25% of members receive individual treatment. It is estimated, on average, members with substance-use challenges spend less than 20 minutes a week in individual treatment. Per staff report, some members are mandated to specific programs or modalities by the correctional system, but the team attempts to coordinate with correctional system representatives to inform them of the availability of services through the F-ACT team.	• Continue efforts to engage members in treatment through the team. • Continue efforts to build working relationships with correctional system representatives in order to demonstrate that the F-ACT team is capable of providing substance abuse treatment, so they do not mandate members receive treatment through external providers. • The program should ensure staff are trained and receive supervision to provide substance abuse or other specialty treatment to the population served. • Ensure F-ACT staff receive appropriate training before providing specialty services (e.g., Dialectical Behavior Therapy), if members are mandated to participate through the correctional system.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (3)	Based on staff report, approximately 22% of members with substance abuse challenges attend group treatment through the F-ACT team at least once monthly. Per staff report, some members are mandated to specific external programs through the correctional system.	• See recommendations for S7.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (4)	Based on documentation, interview, and observation of the morning meeting there is evidence the team primarily uses an integrated dual diagnosis model when working with members who have active substance use challenges, and those who are in recovery. The F-ACT team offers individual and group substance abuse treatment. There is evidence the team generally attempts to work with members to build alliances, and that	• The team should continue to educate correctional system representatives regarding the availability of substance abuse treatment through the F-ACT team. • Continue efforts to implement a consistent, harm-reduction based treatment model that can unify the team approach. Continue to empower SAS staff to cross train other F-ACT staff. • Continue to celebrate member recovery

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			staff attempt to reinforce honest communication about substance use using acceptance and empathy. The team Psychiatrist, SAS and other staff notes support that the team seeks to educate members about substance use and its impact on mental health conditions, to set goals, and to work with members to build awareness of problems. The F-ACT team refers members for detox when medically-necessary (e.g., alcohol, benzodiazepines, and opiates). Although F-ACT team refers out some substance abuse treatment, per report this only occurs when mandated through the correctional system. The team reports they continue to build rapport with correctional system staff to increase their awareness of the F-ACT team and services offered, resulting in some members being referred to substance abuse services through the F-ACT team rather than mandated to outside providers. Some harm reduction efforts were expressed during staff interviews (focusing on the more harmful of two substances) and during the morning meeting. For example, when discussing a member who wanted to obtain a medical marijuana card, rather than dismissing the member's desire, the team SAS reportedly discussed with the person how cannabis use can interfere with medications, and focused discussion with the member on developing a plan if the card was pursued. Various notes in records support the team is aware of a stage-wise approach to treatment. Though most staff appear to support a harm-reduction approach, some may favor abstinence. Staff use some SAMHSA treatment	accomplishments.

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			materials, but staff did not identify a specific treatment model that unified the team approach.	
S10	Role of Consumers on Treatment Team	1 – 5 (5)	Members are employed on the team full-time, with full professional status, and F-ACT team has an identified Peer Support Specialist. F-ACT staff include those with a history of substance use, personal experience with the correctional justice system, and with lived experience of mental illness. Per member report, staff share their personal experiences with members, are supportive, and relatable.	
Total Score:		**4.18**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	4
4. Practicing ACT Leader	1-5	3
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. Substance Abuse 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	4
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	3

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	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.18**	
Highest Possible Score	**5**	