Contra Costa County
Behavioral Health Services
Proposition 47 Evaluation Plan

Prepared by:

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December 2019

Contra Costa County Behavioral Health Services

Proposition 47 Evaluation Plan

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This evaluation plan was developed by Resource Development Associates under contract with the

County of Contra Costa, Behavioral Health Services. Resource Development Associates, 2019

About Resource Development Associates

Resource Development Associates (RDA) is a consulting firm based in Oakland, California, that serves government and nonprofit organizations throughout California as well as other states. Our mission is to strengthen public and non-profit efforts to promote social and economic justice for vulnerable populations. RDA supports its clients through an integrated approach to planning, grant-writing, organizational development, and evaluation.

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Introduction

California voters approved Proposition (Prop) 47 in November 2014 with the goal of lowering incarceration rates across the State by reclassifying certain classes of low-level, non-violent felonies as misdemeanors for individuals who do not have prior convictions for serious offenses. Due to the expected decrease in the State's prison population, the Legislative Analyst's Office estimated annual State correctional savings following implementation of the legislation to be between $150-200 million. Prop 47 requires these State savings to be placed in the Safe Neighborhoods and Schools Fund, and mandates the Board of State and Community Corrections (BSCC) to allocate 65% of the Fund for mental health (MH) and substance use disorder (SUD) treatment that is aimed at reducing recidivism, 25% for crime prevention and support programs in schools, and 10% for trauma recovery services for crime victims. Funds are allocated to local agencies through a competitive grant process administered by the BSCC.

Through the BSCC's Cohort II competitive grant process, Contra Costa County Behavioral Health Services (BHS) was awarded $615,110 over three and a half years (August 2019 - May 2023) to implement CoCo FACT, which will enhance three regional Assertive Community Treatment (ACT) programs to approach fidelity to Forensic Assertive Community Treatment (FACT) in order to provide comprehensive services to individuals eligible for pretrial diversion under AB 1810. BHS is the lead grantee, with program partners including the Public Defender's Office, District Attorney's Office, and the Superior Court, as well as contracted providers (Mental Health Systems and The Hume Center) who will provide FACT services, among others. CoCo FACT leverages the promise of Prop 47 by supporting diversion opportunities for individuals with serious mental illness in order to reduce their criminal justice involvement and provide comprehensive treatment services to support their recovery.

CoCo FACT Program Overview

Coco FACT participants will be identified for diversion through a collaborative multi-departmental partnership between BHS, the District Attorney's Office, the Public Defender's Office, and the Courts. Building on collaborative court processes established through the implementation of Assisted Outpatient Treatment and an array of specialty courts, this team has come together as a result of AB 1810 and is partially supported by AB 1810 funds. The process through which individuals will be diverted into the CoCo FACT program is described below.

Mental Health Diversion Referrals to FACT

Contra Costa County is using Prop 47 funding to pay for pretrial services that individuals will be diverted into through AB 180 mental health diversion. For cases where MH diversion may be an appropriate option, the public defender or a private defense attorney discusses this option with the client and obtains his or her consent to seek diversion. The defense attorney then arranges an independent evaluation of the following **AB 1810 diversion eligibility criteria:**

- Eligible charges: all felony and misdemeanor charges other than murder, voluntary manslaughter, or any offense (except indecent exposure) that requires registration pursuant to Section 290

- Person is clinically considered to have a serious mental illness, including, but not limited to, bipolar disorder, schizophrenia, schizoaffective disorder, or post-traumatic stress disorder, but excluding antisocial personality disorder, borderline personality disorder, and pedophilia
- Mental illness was a contributing factor in committing the crime
- Person is not an unreasonable risk to the community.
- Person is likely to benefit from treatment

If the client meets the AB 1810 eligibility criteria, the defense attorney will request a clinical assessment and development of an individualized treatment plan from BHS's Forensic Mental Health Unit. In addition to the clinical assessment, two additional assessments will be utilized to develop the treatment plan:

- **Historical Clinical Risk Management Tool (HCR-20v3):** Widely used and rigorously validated, the HCR20v3 is required by the California Department of State Hospitals for their conditional release program to help structure decisions about violence risk.
- **Level of Service (LS) instruments LSI-R, LS/RNR, LS/CMI:** LS instruments are recommended by the California Department of State Hospitals for determining risk of recidivism, and assess the rehabilitative needs of offenders, risk of recidivism, and the most relevant factors related to supervision and treatment.

After completing the individualized treatment plan, Forensic Mental Health will send the treatment plan and recommendations to the court. If the client is offered FACT and granted mental health diversion, Forensic Mental Health will make a referral to the FACT team and coordinate program entry with the FACT provider (clients with lower recent acuity or who have low to moderate violence risk or low to moderate recidivism would likely be referred to lower intensity services, and not be consider a part of Prop 47 population). Forensic Mental Health will monitor ongoing delivery of services and provide the court with 90 day progress reports and status updates as needed. All reports will be sent simultaneously to the court, public defender or private defense attorney, and the District Attorney via email and reviewed with the client. Charges will be dropped as per AB 1810 if the client successfully completes the diversion treatment plan within two years.

FACT Program Overview

Funded through Prop 47, Contra Costa County will enhance three regional Assertive Community Treatment (ACT) programs to approach fidelity to Forensic-ACT and provide comprehensive services to individuals eligible for pretrial diversion under AB 1810.

Forensic assertive community treatment (FACT) is a service delivery model intended for individuals with serious mental illness (SMI) who: 1) have complex needs, 2) are involved with the criminal justice system, and 3) need the highest level of care to support their recovery. FACT builds on the evidence-based assertive community treatment (ACT) model by making adaptations to address the criminogenic risk and needs of program participants, however FACT programs should always meet the standards of ACT, described below.

ACT

The ACT model is a comprehensive community-based model of treatment, support, and rehabilitation for individuals who have serious and persistent mental illness, and who do not seek-out support and/or have trouble engaging in traditional office-based programming. Often referred to as a "hospital without walls" ACT uses a multidisciplinary team approach that typically includes a psychiatrist, a nurse, and at least two case managers. **ACT teams are characterized by:**[1]

- Low client to staff ratios,
- Providing services in the community rather than an office setting,
- Shared caseloads among team members,
- 24-hour staff availability, and
- Direct provision of services, including crisis response, by the team.

Distinguishing Service Components of FACT

Forensic ACT is a model that has emerged over the past decade with increasing popularity, likely as a result of the overreliance on the criminal justice system to intervene with people with serious mental illness. It is based on the ACT model, which has a solid evidence base dating back to the 1970s, but does not yet have the same associated evidence base or documented model. However, there are a number of suggestions and key elements of FACT that appear to be important to the forensic modifications, including where referrals come from, the training of staff specific to forensic mental health, the use of cognitive behavioral interventions, the integration of justice agencies on the team, the rehabilitative or recovery orientation, and the presence of supervised housing. Specifically, the literature available for FACT suggests that the primary differences between ACT and FACT are that:

- **Referrals:** FACT accepts referrals solely from justice organizations whereas ACT may accept referrals from a wider net, and
- **Team Staffing:** There is some formal integration of justice partners on a FACT team.[2]

The literature also notes a number of suggestions that may be more likely to increase the success of a FACT team. Specific suggestions include:

- **Staff Training.** While it may be near impossible to staff an entire FACT team with forensic mental health experts, it may be important to ensure that some proportion of staff bring that background

[1] Dartmouth Assertive Community Treatment Scale (DACTS) Protocol: (SAMHSA 1/2003; IUPUI 3/2011; Edited/revised in partnership with the original authors by the Center for Evidence-Based Practices at Case Western Reserve University 1/2017). Retrieved December 17, 2019 from https://www.centerforebp.case.edu/client-files/pdf/act-dacts-protocol.pdf

[2] Lamberti, J. & Weisman, Robert. (2010). Forensic Assertive Community Treatment: Origins, Current Practice, and Future Directions

and that there be ongoing training and/or in-services available to build overall staff capacity to treat justice involved individuals.

- **Programming.** The ACT model includes motivational interviewing and dual recovery interventions. For this population, it is suggested that FACT teams use Cognitive Behavioral Therapy (CBT) interventions and provide supervised housing to program participants. [3]

FACT in Contra Costa County

Contra Costa County's FACT program will be designed to follow the Rochester FACT model. Participants who enroll in FACT will be expected to make between two and four contacts with program staff per week. Core services will include:

- Case management
- Medication management
- Crisis response at all times
- Substance abuse treatment
- Psychotherapy
- Wellness and recovery skills training
- Family and friends support services
- Transportation assistance
- Housing assistance and services
- Employment support services

Enhanced Housing and Employment Services

Because housing and employment statuses are often associated with recidivism, the FACT program will provide increased housing and employment support services to participants. Clients who have immediate housing needs will be placed into subsidized scattered-site or shared housing, with the Coco FACT provider providing a master lease option for prospective landlords of rental units. A housing specialist affiliated with the FACT team will aid in transition from master lease housing to longer term subsidized housing, as well as support with landlord mediation and credit repair.

Contra Costa will also leverage BHS Vocational Services to augment the employment readiness services provided by the FACT team. BHS vocational services provide a full array of employment services, including job search preparation (resume, interviewing), internship placement, apprenticeships, job training, and volunteer placement to help reduce the odds of re-offense and increase prosocial behaviors. Finally, inpatient psychiatric hospitalization, crisis residential treatment, detoxification, or residential drug treatment are available as in-kind services through Contra Costa BHS should clients need brief, higher acuity interventions.

Forensic Elements of Program

Forensic elements of the FACT program will include groups to address criminogenic factors and protective factors, legal leverage to bolster engagement, and ongoing coordination between the program and the courts, among other interventions and service components described in greater detail below.

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[3] Ibid.

- **Seeking Safety:** Evidence-based intervention that incorporates Cognitive Behavioral Therapy with harm reduction interventions to treat post-traumatic stress disorder (PTSD) and substance abuse treatment emphasizing skill development and improved coping responses to address the co-occurring treatment needs of clients in need of diversion services. This intervention has been shown to decrease substance use and trauma symptoms, and improve treatment retention and coping skills, client satisfaction, medication compliance, and treatment attendance.
- **Cognitive Behavioral Social Skills Training (CBSST):** Groups integrating the "Criminal Thinking Curriculum," CBSST is an evidence-based practice combining cognitive behavioral therapy and social skills training to target functional disability in schizophrenia.
- **Coordination with Contra Costa Health Services Health Conductor program:** FACT consumers will have access to a peer/therapist co-lead reentry support group. The program offers a place for building community for all people returning from incarceration to begin the process of cognitive restructuring, character refinement, and cultural realignment to facilitate re-integration into the community. In addition to building these reentry success skills, the Health Conductors program offers a path to become a peer-leader, assistance with benefits access, volunteer opportunities, enrollment assistance in GA, Cal Fresh, SSI/SSA benefits, and a medical clinic devoted to the reentry population.

FACT Goals and Objectives

As depicted in Table 1 and the program's logic model (see Appendix A), CoCo FACT plans to improve the lives of program participants by decreasing criminal justice involvement through improved behavioral health functioning resulting from the delivery of comprehensive, multidisciplinary, and culturally relevant FACT services that address criminogenic factors and socio-economic issues impacting re-offense and incarceration.

Table 1. Goals and Objectives of Prop 47 Activities in Contra Costa County

Goals	Objectives for Target Population
Improve behavioral health functioning by delivering comprehensive, multidisciplinary and culturally relevant behavioral health services through Forensic Assertive Community Treatment.	Reduce frequency of hospitalizations
	Reduce days of institutional care
	Reduce psychiatric emergency room use
	Increase number of consumers utilizing lower levels of care, or "stepping down" from CoCo FACT to outpatient mental health and/or substance abuse disorder treatment
Reduce recidivism by offering intensive behavioral health and other supportive services that address criminogenic factors and socio-economic issues impacting re-offense and incarceration.	Reduce number of arrests
	Reduce number of days of incarceration

Improve positive participation and integration in the community through supportive housing, independent living, and vocational services that promote self-sufficiency.	Fewer people are homeless at program completion compared to pre-enrollment homeless
	Increase the number of people who are employed at program completion compared to pre-enrollment employment

Evaluation Overview

In December 2019, Contra Costa County Behavioral Health Services contracted Resource Development Associates (RDA) to conduct an evaluation of the FACT program concluding in May 2023. RDA will evaluate how successful Prop 47 activities in Contra Costa County have been in attaining established goals. The process and outcome evaluation will examine the extent to which Prop 47 activities are implemented as intended and the impact of these activities on client outcomes, including recidivism.[4] In addition, RDA will work in an advisory role with agencies and organizations associated with Prop 47 and the FACT program during early implementation to facilitate data collection and sharing; identify and address challenges; provide technical assistance; and offer recommendations for continuous improvement. The evaluation goals and questions identified in the following sections reflect the theory of change, outcomes, and impacts illustrated in the Contra Costa County Proposition 47 Logic Model in Appendix A.

Evaluation Questions

The following evaluation questions reflect the purpose of the evaluation, helping to guide evaluation activities, and ensure that appropriate data are collected and local priorities are addressed. RDA will provide BHS with an evaluation that complies with Prop 47 and California Board of State and Community Corrections (BSCC) reporting requirements and provides additional information to inform the County, stakeholders, and community about how implementation of CoCo FACT has affected behavioral health access and the criminal justice involvement of program participants, assessing both individual-level outcomes for those who receive services, and resulting systems-level changes.

Process Evaluation Questions:

1. **How has CoCo FACT been implemented? Does the program follow the intended design of the Rochester FACT Model to fidelity? What changes, if any, were necessary?**

2. **What successes and challenges have program partners experienced implementing CoCo FACT?**

3. **Who is being served by CoCo FACT, what types of services are they receiving, and with what duration and frequency?**

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[4] Per the BSCC, recidivism is defined as "conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal conviction."

The process evaluation questions seek to assess implementation of CoCo FACT, including the pretrial diversion process that leads to FACT enrollment, in order to facilitate continuous quality improvement. They focus on the who, what, when, and how of program activities. Evaluation Questions One and Two evaluate implementation, assessing the extent to which services are implemented as planned, identifying any successes and challenges with implementation. Evaluation Question One also includes an assessment of the program's fidelity to the Rochester FACT model, which includes an assessment of ACT fidelity.[5] ACT done to fidelity produces reliable outcomes, and will be measured as a part of the FACT fidelity assessments included in the interim and final evaluations. By measuring fidelity, the evaluation will help to ensure that CoCo FACT consumers are receiving the expected level of services while also providing a benchmark from the literature about expected outcomes. By assessing program fidelity on a yearly basis, RDA and BHS can also examine the quality of service provision and track improvements in administering FACT services to fidelity. Evaluation Question Three focuses on who is being served by CoCo FACT, and the services they receive through the FACT program.

Findings from these evaluation questions will support continuous quality improvement and provide lessons learned for County partners. By understanding the project's implementation process, we will be able to best understand how the outcomes examined in the *Outcome Evaluation Questions* are achieved.

Outcome Evaluation Questions:

4. **To what extent does CoCo FACT reduce homelessness, increases employment opportunities, and improve psychosocial outcomes among program participants?**

5. **To what extent does CoCo FACT contribute to reductions in the use of crisis services; psychiatric emergency room visits; hospitalizations and institutional stays; incarceration; and new criminal convictions among program participants?**
6. **To what extent do FACT consumers "step down" to lower levels of care, such as outpatient mental health or substance use disorder treatment services?**

Evaluation Questions Four through Six assess the extent to which the CoCo FACT program is able to achieve intended outcomes. These questions focus on consumers' outcomes and the goals of the program, including improving consumers' housing and employment opportunities as well as psychosocial outcomes, and reducing consumers' crisis experiences, hospitalizations, and criminal justice involvement. Also, given that a key component of the FACT model is that consumers are successfully transitioned to appropriate ongoing treatment, BHS is interested in understanding how and to which types of programs consumers "step down" from the FACT program. Results from these evaluation questions will determine the effectiveness of the CoCo FACT program for consumers. In combination with the findings of the

[5] Lamberti, J. Steven, et al. "A Randomized Controlled Trial of the Rochester Forensic Assertive Community Treatment Model." Psychiatric Services, vol. 68, no. 10, 1 June 2017, pp. 1016–1024., doi:10.1176/appi.ps.201600329.

Process Evaluation Questions, the findings from these outcome evaluation questions will establish an understanding of how and why certain outcomes were or were not achieved.

Data Sources and Collection

RDA will rely on numerous data sources in order to answer the evaluation questions and complete the process and outcome evaluations of the CoCo FACT program. RDA intends to utilize the following quantitative data sources:

- Behavioral Health Services Electronic Health Record (EHR)
- MHSA Data Collection and Reporting System (DCR)
- FACT Team Database (if not available from EHR)
- Public Defender's Case Management System
- District Attorney's Case Management System
- Sheriff's Office Jail Management System
- Contra Costa Superior Court Case Management System

In addition, RDA will conduct focus groups and/or interviews with a variety of entities, including:

- FACT Consumers and Family Members
- FACT Providers' Staff
- Pretrial Diversion and FACT Partners (e.g. BHS, Public Defender's Office, Mental Health Court Judge, etc.)

Table 2 below provides examples of the indicators and data measures that will be used to answer the evaluation questions, as well as the data sources for each measure. As RDA conducts the evaluation and depending on the data available, the way we measure each indicator may evolve.

Table 2. Indicators and Data Measures for each Evaluation Question

Question		Indicators & Data Measures	Data Sources
Process	1	Documentation of pretrial diversion and FACT program	Proposals, Plans, Implementation Documents
		Reasons for any changes to program	Focus Groups & Interviews
		FACT Fidelity scores	BHS EHR, BHS EHR, Focus Groups & Interviews, Sheriff's Office JMS, Superior Court CMS, Document Review, Program Observation
	2	Pretrial diversion and FACT program implementation successes & challenges	Focus Groups & Interviews
	3	Number of individuals assessed by the pretrial diversion program	Public Defender's CMS, District Attorney's CMS, Superior Court CMS
		Number of individuals granted MH Diversion	BHS EHR
		Number of individuals enrolled in the FACT program through MH Diversions	BHS EHR
		Number of individuals enrolled in other programs through MH Diversion	BHS EHR

Question		Indicators & Data Measures	Data Sources
		FACT participant demographics (e.g. race, gender, age, employment, etc.)	BHS EHR
		FACT participants clinical profile (e.g. diagnoses, substance use, comorbidities, etc.)	BHS EHR
		Type of services received (e.g. medication management, CBSST, housing, etc.)	BHS EHR
		Frequency and duration of encounters	BHS EHR
Outcome	4	Consumers' housing and employment status	DCR, Focus Groups & Interviews
		Consumers' psychosocial behavior (e.g. social functioning, substance use, recovery, etc.)	FACT Team Database, Focus Groups & Interviews
	5	Consumers' crisis and psychiatric emergency services (e.g. number and duration of episodes)	BHS EHR
		Consumers' hospitalizations (e.g. number and duration of episodes)	BHS EHR
		Consumers' incarceration and criminal convictions	Sheriff's Office JMS, Superior Court CMS
	6	Consumers' FACT episode dispositions (e.g. complete, termination)	BHS EHR, Focus Groups & Interviews
		Consumers' subsequent service or treatment (e.g. outpatient services, criminal proceedings)	BHS EHR, Superior Court CMS

Data Transmission and Protecting Privacy

Contra Costa BHS and RDA will use a Secure File Transfer Portal (SFTP) server to share data for this evaluation. BHS will password-protect the files and upload them to the SFTP site. RDA will download and store the files on a secure drive that only the FACT evaluation team can access. Both qualitative and quantitative data will be stored on this secure drive. No data will be transported remotely or offsite. RDA will destroy data after the end of the evaluation. In order to ensure that all data is anonymous and individual's HIPAA rights are protected, RDA will aggregate all data collected so that no one can be individually identified in the evaluation reports presented. To further protect the integrity of this process, we will submit our plans to an Institutional Review Board for approval before conducting our research. This group will review the evaluation plans in detail with the aim to protect the rights and welfare of human research subjects.

Analytic Framework

For the purposes of this evaluation, RDA will utilize a mixed methods approach that includes both quantitative and qualitative data collection and analyses. There are varieties of mixed methods approaches, all of which combine or integrate qualitative and quantitative data to maximize the strengths

of the data while minimizing the weaknesses.[6] Mixed methods research designs generally fall into two categories: 1) collecting qualitative and quantitative data concurrently and integrating data during the analysis; or 2) collecting and analyzing one type of data first (qualitative or quantitative) and then using the results to inform the next phase of the project where the other type of data will be collected. RDA plans to use both approaches in this evaluation. The evaluation team may integrate qualitative and quantitative data analyses in various ways, including:

Consecutive Approaches

- Quantitative results may direct qualitative inquiry. For example, findings from the interim evaluation quantitative analyses may suggest questions for a future focus group or interview to conduct for the final evaluation.
- Qualitative results may direct quantitative inquiry also. For example, an emerging theme from the qualitative data may suggest a phenomenon or additional quantitative analyses not yet considered.

Concurrent Approaches

- Use of qualitative data to contextualize the results of the quantitative analysis.
- Use of qualitative data to support or refute quantitative results.
- Quantifying qualitative data (e.g., number of occurrences of a theme) to compare to quantitative results.

RDA's evaluation team will be flexible in adapting its analytic procedures in order to accommodate the quantity and quality of data obtained over the course of the evaluation. The following sections describe the analytic strategies the evaluation team will perform to answer each of the evaluation questions.

Evaluation Questions 1 & 2

1. **How has CoCo FACT been implemented? Does the program follow the intended design of the Rochester FACT Model to fidelity? What changes, if any, were necessary?**

2. **What successes and challenges have program partners experienced implementing CoCo FACT?**

Analysis Strategy:

RDA proposes to engage in a process to document the Pretrial Diversion and FACT model as planned and/or newly implemented in Contra Costa. Areas of specific inquiry will include target population, referral sources and process, structure for collaboration with justice partners, training plans, and services and supports to be included. In order to accomplish this, RDA will review any materials submitted to the

[6] National Institute of Health: Office of Behavioral and Social Sciences. *Best practices for mixed methods research in the health sciences.* Retrieved March 31, 2014 from: http://obssr.od.nih.gov/scientific_areas/methodology/mixed_methods_research/section2.aspx

Department of State Hospital and BSCC regarding pretrial diversion and the FACT team and interview representatives from partner agencies.

Additionally, RDA will commence a fidelity monitoring assessment for each of the three CoCo FACT teams with the assessment rubric developed by RDA, which will include elements of the Dartmouth Assertive Community Treatment Fidelity Scale (DACTS) and the Rochester FACT scale (FACTS).[7] The fidelity monitoring process includes scheduling and preparing the teams for a site visit as well as requesting service data from the providers and BHS for those enrolled in FACT. During the site visit, RDA assessors will interview the team leader and staff, observe the daily team meeting, and meet with consumers and family members. Within 30 days, RDA will provide a fidelity assessment and facilitate a meeting with each team and BHS to review the results, highlight areas of strength, and offer any observed opportunities for further alignment to the model.

Evaluation Question 3

3. **Who is being served by CoCo FACT, what types of services are they receiving, and with what duration and frequency?**

Analysis Strategy:

The evaluation team will calculate descriptive statistics (e.g., means, frequencies, percentages) to examine the specific attributes of FACT consumers such as race/ethnicity, gender, housing, education, income, clinical profile (e.g., primary diagnosis, presence of co-occurring substance abuse disorder, etc.), and service history. In addition to analyzing consumers enrolled in FACT, RDA will examine the profiles of all individuals in the pretrial diversion program. Descriptive statistics will be calculated for non-FACT pretrial diversion consumers and relevant comparisons between groups will be reported. This consumer information is expected to be available through the BHS EHR.

There will also be variations in the levels of services that consumers will receive, as well as their levels of participation and retention. In order to continue to better understand consumers and their needs, the evaluation team will examine the types, frequencies, and durations of services and programs that they access and then utilize.

Evaluation Questions 4, 5, & 6

4. **To what extent does CoCo FACT reduce homelessness, increase employment opportunities, and improve psychosocial outcomes among program participants?**

5. **To what extent does CoCo FACT contribute to reductions in the use of crisis services; psychiatric emergency room visits; hospitalizations and institutional stays; incarceration; and new criminal convictions among program participants?**

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[7] See Appendix B and Appendix C for the DACTS and FACTS assessment rubrics.

6. **To what extent do FACT consumers "step down" to lower levels of care, such as outpatient mental health or substance use disorder treatment services?**

Analysis Strategy:

To explore outcomes among CoCo FACT consumers, RDA will employ a pre-/post-test design to analyze means, medians, standard deviations, and ranges to examine consumers' outcomes before and after enrollment in FACT. In other words, RDA will use each consumer's previous service history (before enrollment in FACT) to establish their baseline-level of data and then analyze changes including psychosocial functioning, well-being, and criminal justice involvement from baseline to follow-up.

RDA will use consumer data collected before enrollment to make within-consumer comparisons of identified outcomes over time. Data for these outcomes measures is available from BHS EHR, Sheriff's Office Jail Management System, Contra Costa Superior Court Case Management System, and the FACT Team Database (if not all necessary data and assessments are available in the EHR). RDA will collect consumer data from three years prior to and after enrollment for each episode in order to assess change in the stated outcome measures. Given the greater time period for which data is available prior to FACT enrollment, RDA will standardize outcomes to six-month intervals (per 180 days).

RDA will also perform a paired t-test or Wilcoxon signed-rank test to evaluate whether there are differences in mean outcome values pre- and post-enrollment among FACT consumers. These statistical techniques are used to compare averages in correlated samples when examining observations on the same subjects. These methods will be used for both the pre-/post-test and consumer population comparisons.

Additionally, the evaluation will report how consumers are discharged from the CoCo FACT program. RDA will calculate descriptive statistics (e.g., means, frequencies, percentages) regarding successful completions and services consumers are connected to, or terminations from the program and any continued criminal proceedings. As appropriate and dependent on the availability of data, additional analyses and comparisons will be made regarding consumers' completions of the FACT program.

These quantitative analyses will be integrated with findings from assessment tools used by the FACT team and focus groups and/or key information interviews. RDA will utilize repeated assessments, as available, as well as information from focus group and interviews to further explore and understand consumers outcomes.

Potential Limitations

As with any evaluation or research project that takes place in "real world" settings, limitations exist. Although RDA identified the objectives of this evaluation above, the underlying findings may change depending on the implementation of Prop 47 and the FACT program in Contra Costa County, data availability, and the sample sizes of FACT consumers.

The evaluation team cannot predict the number of individuals who will participate in the program over the course of the next three and a half years. While it is appropriate to conduct pre/post-test analyses to

determine changes in psychosocial outcomes, psychiatric hospitalizations, and criminal justice involvement prior to and post CoCo FACT involvement, RDA can only conduct change-over-time analyses if there is an adequate number of individuals who participate in the program during the evaluation period. While comparisons can be made with small populations, a few "outlying" individuals can lead to significant shifts in the data requiring caution when interpreting results.

It is also important to note that there will be more data available pre-program involvement compared to the shorter post-program enrollment periods (especially for those who enroll in CoCo FACT towards the end of the evaluation period). Therefore, CoCo FACT consumers will have greater opportunities to experience various outcomes prior to program involvement than after program involvement. To account for differences in the pre- and post-time periods, RDA will standardize outcomes measures to rates per 180 days. Nevertheless, because the limited time period of the evaluation, there is less opportunity for consumers to experience outcomes such as hospitalization, arrest, and/or incarceration post FACT enrollment.

Lastly, this evaluation is dependent on the availability of data. The data sources listed in above and in Table 2 would provide the necessary information to answer the evaluation questions presented. Without these data, RDA will work with BHS and the FACT team to assess possible alternatives and potential adjustments to analyses.

Evaluation Reporting

In order to comply with the Board of State and Community Corrections (BSCC) requirements for Prop 47 grant funding, RDA will draft an interim and final evaluation report that provide a comprehensive understanding of the implementation and impact of the Contra Costa's Forensic Assertive Community Treatment (FACT) program and the pretrial diversion process for FACT consumers. These reports will address the evaluation questions, including any information about the implementation progress of the FACT program and fidelity assessment, outcome measures for the target population, and recommendations for actionable program improvements. The two-year preliminary report will assess the program's progress toward achieving its goals, while the final evaluation report will examine the program's results and document the program's overall impact and efficacy.

For each report, RDA will aggregate all quantitative process and outcome data collected to assess program implementation as well as individual- and program-level outcomes achieved to date. We will also conduct focus groups and/or key informant interviews with the myriad of stakeholders and program partners to learn about how the program is being implemented, consumers' experiences with program services, perceptions of the program's impact, as well as any recommendations for program improvement.

Quantitative and qualitative data will be aggregated, analyzed, and synthesized using qualitative content analysis, descriptive statistics, and inferential statistics, as appropriate. Qualitative and quantitative analysis results will be integrated to develop key findings and inform recommendations for program improvement.

After conducting preliminary qualitative and quantitative analyses, we will meet with Contra Costa County project team to review and discuss the initial findings before finalizing them for reporting purposes. Each

report will also include a set of data-driven recommendations intended to strengthen and improve the program processes and outcomes. We will provide draft evaluation reports to the project team for review beforehand and will incorporate any feedback prior to finalizing the report for submission to the BSCC.

Appendix A. CoCo FACT Logic Model

Table 3. Pretrial Diversion and FACT Program Logic Model

Process			Outcomes & Impact	
Inputs	Activities	Outputs/Service Delivery	Short- & Middle-Term Outcomes (0-2 years)	Long-Term Outcomes and Impacts (3-5 years)
Funding • BSCC Prop 47 grant funding • AB 1810 funding • Leveraged funds **Leadership, Oversight, & Staffing** • Partnerships ○ Behavioral Health Services ○ Probation ○ District Attorney ○ Law Enforcement ○ CBOs • Local Advisory Committee • Dedicated staff: 0.5 FTE Forensic Program Supervisor **EBPs & Trainings** • Predictive Risk Score • Historical Clinical Risk Tool • Level of Service Instruments • ACT Model • Seeking Safety • Cognitive Behavioral Social Skills Training • Restorative Justice **Existing Services & Resources** • CCHS Health Conductor Program • Community Works West • BHS Vocational Services	**MH Diversion to FACT** • Identification, Screening, & Assessment ○ AB 1810 Eligibility Assessment ○ Clinical Assessment ○ Predictive Risk Score ○ Historical Clinical Risk Tool ○ Level of Service Instruments • Development of individualized treatment plan • MH Diversion referral **ACT Model** • Multidisciplinary team • Low client to staff ratios • Providing services in the community rather than an office setting • Shared caseloads among team members • 24-hour staff availability • Direct provision of services, including crisis response, by the team **Forensic Components of FACT Model** • ACT to fidelity • Staffing w/ forensic experience • Forensic training for staff • Cognitive Behavioral Social Skills Training • Seeking Safety • Restorative Justice (Community Works West) • Health Conductor program (CC Health Services) • Enhanced Housing Support Services • Enhanced Vocational Services	**MH Diversion to FACT** • # of MH diversion eligibility assessments • # of individuals assessed, by assessment • # of individual treatment plans developed • # of consumers granted MH Diversion • # referred to FACT for treatment • Demographics and clinical profile **CoCo FACT Services** • # enrolled in FACT • # receiving services, by type of service • Frequency and duration of service encounters • # of consumers adherent to FACT Model • Demographics and clinical profile **Enhanced Housing Services** • Consumer housing status, overtime • # offered housing services • # receiving housing services, by type of service **Enhanced Vocational Services** • Consumer employment status, overtime • # offered vocational services • # receiving vocational services, by type of service	**Mental Health** • Improvements in FACT consumers' psychosocial outcomes • Reduction in co-occurring disorders • Reduction in FACT consumers' psychiatric hospitalizations and psychiatric emergency room admissions • FACT consumers are "stepped down" after successful progress to ongoing MH treatment **Housing** • Increased number of consumers are stably housed **Employment** • Increased number of consumers receiving vocational services and/or employed **Criminal Justice System** • Reduction in FACT consumers' incarcerations and criminal convictions **System Level Outcomes** • Improved coordination and greater efficiency between pretrial diversion partners • Improved coordination and greater efficiency between FACT partners	**Mental Health** • FACT consumers are stabilized through community-based mental health and SUD treatment and services **Housing** • FACT consumers with housing needs maintain their stable housing **Employment** • FACT consumers attain and maintain employment **Criminal Justice System** • FACT consumers do not recidivate within three years of release or placement on supervision, per the BSCC definition **System Level Outcomes** • Community partnerships and collaboration for MH treatment and housing • Reduced recidivism • Reduced psychiatric hospitalizations and psychiatric emergency room admissions

Appendix B. Rochester FACT Treatment Scale

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Forensic Assertive Community Treatment Scale (FACTS)
WORKING DRAFT

Criterion	1	2	3	4	5
1. ACT TEAM COMPONENT: Forensic Assertive Community Treatment (FACT) programs include an ACT team component with high fidelity on the Dartmouth Assertive Community Treatment Scale (DACTS)	The ACT team component scores less than 1.0 on the DACTS	The ACT team component scores between 1.0 and 1.9 on the DACTS	The ACT team component scores between 2.0 and 2.9 on the DACTS	The ACT team component scores between 3.0 and 3.9 on the DACTS	The ACT team component scores 4.0 or higher on the DACTS
2. RISK FACTOR FOCUS: FACT teams identify and address risk factors for criminal recidivism, including psychosis, antisocial personality, criminal companions, co-occurring substance use, lack of healthy leisure pursuits, work/school problems and family/marital problems	The FACT team uses interventions that address three or fewer established risk factors for criminal recidivism	The FACT team uses interventions that address at least four established risk factors for criminal recidivism	The FACT team uses interventions that address at least five established risk factors for criminal recidivism	The FACT team uses interventions that address at least six established risk factors for criminal recidivism	The FACT team uses interventions that address at least seven established risk factors for criminal recidivism
3. CRIMINAL JUSTICE-INVOLVED CLIENTS: FACT teams serve only clients who are involved with the criminal justice system	≤61% of all FACT team clients are involved with the criminal justice system	61%-70% of all FACT team clients are involved with the criminal justice system	71%-80% of all FACT team clients are involved with the criminal justice system	81%-90% of all FACT team clients are involved with the criminal justice system	≥90% of all FACT team clients are involved with the criminal justice system

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4. PARTNERSHIP WITH CRIMINAL JUSTICE AGENCY REPRESENTATIVES: FACT teams work in partnership with criminal justice agency representatives, such as judges, probation or parole officers, police officers, and/or pre-trial service workers	No partnership is identified between the FACT clinical team and any criminal justice agency	Representatives from the FACT clinical team and a criminal justice agency indicate that their respective agencies work together somewhat closely	Representatives from the FACT clinical team and a criminal justice agency indicate that their respective agencies work together closely	Representatives from the FACT clinical team and a criminal justice agency indicate that their respective agencies work together very closely	Representatives from the FACT clinical team and a criminal justice agency indicate that their respective agencies work together extremely closely
5. INTERAGENCY COLLABORATION: FACT programs involve collaboration between the parent agencies of the FACT clinical team and its criminal justice partner	Level of collaboration scores less than 1.0 on the Interagency Collaboration Activities Scale (ICAS)	Level of collaboration scores between 1.0 and 1.9 on the Interagency Collaboration Activities Scale (ICAS)	Level of collaboration scores between 2.0 and 2.9 on the Interagency Collaboration Activities Scale (ICAS)	Level of collaboration scores between 3.0 and 3.9 on the Interagency Collaboration Activities Scale (ICAS)	Level of collaboration scores 4.0 or higher on the Interagency Collaboration Activities Scale (ICAS)
6. SHARED TRAINING: FACT team clinicians and criminal justice agency representatives receive ongoing education and training to promote collaboration	FACT clinicians and partner agency representatives receive training less that one hour every 12 months	FACT clinicians and partner agency representatives receive training at least one hour every 12 months	FACT clinicians and partner agency representatives receive training at least one hour every nine months	FACT clinicians and partner agency representatives receive training at least one hour every six months	FACT clinicians and partner agency representatives receive training at least one hour every three months
7. SHARED ELIGIBILITY CRITERIA: FACT programs have clear eligibility criteria that incorporate clinical and criminal justice criteria	No eligibility criteria can be identified	Eligibility criteria do not incorporate both clinical and criminal justice criteria	Eligibility criteria incorporate both clinical and criminal justice criteria, but are somewhat ambiguous	Eligibility criteria incorporate both clinical and criminal justice criteria, are clear, but are not written	Eligibility criteria incorporate both clinical and criminal justice criteria, are clear, and are written
8. COMBINED TEAM	FACT team	FACT team clinicians	FACT team clinicians	FACT team clinicians	FACT team clinicians

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MEETINGS: FACT team clinicians and representatives of a partner criminal justice agency meet regularly	clinicians and representatives of the partner agency meet less frequently than bimonthly	and representatives of the partner agency meet at least bimonthly	and representatives of the partner agency meet at least monthly	and representatives of the partner agency meet at least biweekly	and representatives of the partner agency meet at least weekly
9. WRITTEN PARTICIPATION AGREEMENT: FACT participants receive clear information about terms of participation including treatment and attendance expectations, and legal terms and conditions	A written participation agreement is signed by <61% of all FACT program participants	A written participation agreement is signed by 61%-70% of all FACT program participants	A written participation agreement is signed by 71% - 80% of all FACT program participants	A written participation agreement is signed by 81% - 90% of all FACT program participants	A written participation agreement is signed by >90% of all FACT program participants
10. INFORMATION SHARING AGREEMENT: A written agreement is signed by all clients authorizing sharing of confidential information between FACT team clinicians and a partnering criminal justice agency	An information sharing agreement is signed <61% of all clients currently enrolled in the FACT program	An information sharing agreement is signed 61-70% of all clients currently enrolled in the FACT program	An information sharing agreement is signed by 71%-80% of all clients currently enrolled in the FACT program	An information sharing agreement is signed by 81%-90% of all clients currently enrolled in the FACT program	An information sharing agreement is signed by >90% of all clients currently enrolled in the FACT program
11. ADHERENCE MONITORING: Clients' adherence to their participation agreements is regularly monitored and reviewed by FACT team clinicians in conjunction with criminal justice agency representatives	Information about clients' adherence is discussed by FACT clinicians and criminal justice agency representatives less frequently than bimonthly	Information about clients' adherence is discussed by FACT clinicians and criminal justice agency representatives at least bimonthly	Information about clients' adherence is discussed by FACT clinicians and criminal justice agency representatives at least monthly	Information about clients' adherence is discussed by FACT clinicians and criminal justice agency representatives at least biweekly	Information about clients' adherence is discussed by FACT clinicians and criminal justice agency representatives at least weekly
12. CLINICALLY INFORMED DECISION	FACT team clinicians feel that	FACT team clinicians feel that their criminal	FACT team clinicians feel that their criminal	FACT team clinicians feel that their criminal	FACT team clinicians feel that their criminal

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MAKING: FACT criminal justice representatives carefully consider input from FACT team clinicians in making legal decisions about how to manage participation agreement violations and other client behavioral problems	their criminal justice partner never considers their clinical opinion in deciding how to manage a client's behavioral problems	justice partner considers their clinical opinion very little in deciding how to manage a client's behavioral problems	justice partner considers their clinical opinion somewhat in deciding how to manage a client's behavioral problems	justice partner usually considers their clinical opinion in deciding how to manage a client's behavioral problems	justice partner always considers their clinical opinion in deciding how to manage a client's behavioral problems
13. TRANSITION PROCEDURES: FACT programs successfully transition program completers to receive ongoing mental health treatment	<61% of clients who complete the program are successfully transitioned to aftercare	61%-70% of clients who complete the program are successfully transitioned to aftercare	71%-80% of clients who complete the program are successfully transitioned to aftercare	81%-90% of clients who complete the program are successfully transitioned to aftercare	>90% of clients who complete the program are successfully transitioned to aftercare

References:

1. Teague GB, Bond GR, and Drake RE. Program fidelity in assertive community treatment: Development and use of a measure. American Journal of Orthopsychiatry, 68(2):216 – 232, 1998

2. Dedrick RF and Greenbaum PE. Multilevel confirmatory factor analysis of a scale measuring interagency collaboration of children's mental health agencies. Journal of Emotional and Behavioral Disorders, 19(1):27 – 40, 2011

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Appendix C. Dartmouth ACT Fidelity Scale

Team: ______________________ **Date:** ______________ .

	CRITERION	RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)
	HUMAN RESOURCES: STRUCTURE & COMPOSITION					
H1	SMALL CASELOAD: client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	11 - 20	10 clients/clinician or fewer
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 36%.	37 - 63%.	64 - 89%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.
H3	ACT TEAM MEETING: ACT Team meets frequently to plan and review services for each client.	ACT Team service-planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	ACT Team meets at least 4 days/week and reviews each client each time, even if only briefly.
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.
H5	CONTINUITY OF STAFFING: ACT Team maintains same staffing over time.	Greater than 80% turnover in 2 years.	60-80% turnover in 2 years.	40-59% turnover in 2 years.	20-39% turnover in 2 years.	Less than 20% turnover in 2 years.
H6	STAFF CAPACITY: ACT Team operates at full staffing.	ACT Team has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	80-94%	ACT Team has operated at 95% or more of full staffing in past 12 months.
H7	PSYCHIATRIST/ PSYCHIATRIC PRESCRIBER ON STAFF: there is at least one full-time psychiatrist per 100 clients assigned to work with the ACT Team.	ACT Team for 100 clients has less than .10 FTE regular psychiatrist/ psychiatric prescriber.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	.70-.99 FTE per 100 clients.	At least one full-time psychiatrist/psychiatric prescriber is assigned directly to a 100-client ACT Team.
H8	NURSE (RN) ON STAFF: there are at least two full-time nurses (RNs) assigned to work with a 100-client ACT Team.	ACT Team for 100 clients has less than .20 FTE regular nurse.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client ACT Team.

Dartmouth Assertive Community Treatment Scale (1/2003; 3/2011; 1/2017) 1

Team: ______________________ **Date:** ____________ .

	CRITERION	(1)	(2)	(3)	(4)	(5)
H9	SUBSTANCE ABUSE SPECIALIST ON STAFF: a 100-client ACT Team includes at least two staff members with 1 year of training or clinical experience in substance abuse treatment.	ACT Team has less than .20 FTE S/A expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year S/A training or supervised S/A experience.
H10	VOCATIONAL SPECIALIST ON STAFF: the ACT Team includes at least two staff members with 1 year training/experience in vocational rehabilitation and support.	ACT Team has less than .20 FTE vocational expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.
H11	ACT TEAM SIZE: team is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.	ACT Team has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	7.5 - 9.9	ACT Team has at least 10 FTE staff.

ORGANIZATIONAL BOUNDARIES

	CRITERION	(1)	(2)	(3)	(4)	(5)
O1	EXPLICIT ADMISSION CRITERIA: ACT Team has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	ACT Team has no set criteria and takes all types of cases as determined outside the ACT Team.	ACT Team has a generally defined mission but the admission process is dominated by organizational convenience.	The ACT Team makes an effort to seek and select a defined set of clients but accepts most referrals.	ACT Team typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	The ACT Team actively recruits a defined population and all cases comply with explicit admission criteria.
O2	INTAKE RATE: ACT Team takes clients in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 clients/month.	13 -15	10 - 12	7 - 9	Highest monthly intake rate in the last 6 months no greater than 6 clients/month.

Team: ______________________________ **Date:** ______________ .

CRITERION		RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)
O3	FULL RESPONSIBILITY FOR TREATMENT SERVICES: in addition to case management, the ACT team directly provides psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services.	ACT Team provides no more than case management services.	ACT Team provides one of five additional services and refers externally for others.	ACT Team provides two of five additional services and refers externally for others.	ACT Team provides three or four of five additional services and refers externally for others.	ACT Team provides all five of these services to clients.
O4	RESPONSIBILITY FOR CRISIS SERVICES: ACT Team has 24-hour responsibility for covering psychiatric crises.	ACT Team has no responsibility for handling crises after hours.	Emergency service has ACT Team-generated protocol for ACT clients.	ACT Team is available by telephone, predominantly in consulting role.	ACT Team provides emergency service backup; e.g., ACT Team is called, makes decision about need for direct ACT Team involvement.	ACT Team provides 24-hour coverage.
O5	RESPONSIBILITY FOR HOSPITAL ADMISSIONS: ACT Team is involved in hospital admissions.	ACT Team has involvement in fewer than 5% decisions to hospitalize.	ACT team is involved in 5% -34% of admissions.	ACT team is involved in 35% - 64% of admissions.	ACT team is involved in 65% - 94% of admissions.	ACT team is involved in 95% or more admissions.
O6	RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: ACT Team is involved in planning for hospital discharges.	ACT Team has involvement in fewer than 5% of hospital discharges.	5% - 34% of ACT Team client discharges are planned jointly with the ACT Team.	35 - 64% of ACT Team client discharges are planned jointly with the ACT Team.	65 - 94% of ACT Team client discharges are planned jointly with the ACT Team.	95% or more discharges are planned jointly with the ACT Team.
O7	TIME-UNLIMITED SERVICES (GRADUATION RATE): ACT Team does not have arbitrary time limits for clients admitted to the team but remains the point of contact for all clients as needed.	More than 90% of clients are discharged within 1 year.	From 38-90% of clients are discharged within 1 year.	From 18-37% of clients are discharged within 1 year.	From 5-17% of clients are discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% graduating annually.

Team: ______________________________ **Date:** ____________ .

NATURE OF SERVICES

	CRITERION	(1)	(2)	(3)	(4)	(5)
S1	COMMUNITY-BASED SERVICES: ACT Team works to monitor status and develop skills in the community rather than function as an office-based team.	Less than 20% of face-to-face contacts in community.	20 - 39%.	40 - 59%.	60 - 79%.	80% of total face-to-face contacts in community
S2	NO DROPOUT POLICY: ACT Team engages and retains clients at a mutually satisfactory level (ACT Team high percentage of its clients).	Less than 50% of the caseload is retained over a 12-month period.	50- 64%.	65 - 79%.	80 - 94%.	95% or more of caseload is retained over a 12-month period.
S3	ASSERTIVE ENGAGEMENT MECHANISMS: ACT Team uses street outreach, motivational/ engagement techniques, as well as legal mechanisms (e.g., probation/parole, OP commitment, payeeship, guardianship) or other techniques to ensure ongoing engagement.	ACT Team passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	ACT Team makes initial attempts to engage but generally focuses efforts on most motivated clients.	ACT Team attempts outreach and uses legal mechanisms only as convenient.	ACT Team usually has plan for engagement and uses most of the mechanisms that are available.	ACT Team demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.
S4	INTENSITY OF SERVICE: high amount of face-to-face service time as needed.	Average of less than 15 min/week or less of face-to-face contact per client.	15 - 49 minutes / week.	50 - 84 minutes / week.	85 - 119 minutes / week.	Average of 2 hours/week or more of face-to-face contact per client.
S5	FREQUENCY OF CONTACT: high number of face-to-face service contacts as needed.	Average of less than 1 face-to-face contact / week or fewer per client.	1.00 - 1.99 / week.	2.00 - 2.99 / week.	3.00 - 3.99 / week.	Average of 4.00 or more face-to-face contacts / week per client.
S6	WORK WITH INFORMAL SUPPORT SYSTEM: with or without client present, ACT Team provides support and skills for client's support network: family, landlords, employers.	Less than .50 contact per month per client with support system.	.50-.99 contact per month per client with support system in the community.	1.00-1.99 contact per month per client with support system in the community.	2.00-3.99 contacts per months per client with support system in the community.	4.00 or more contacts per month per client with support system in the community.

Team: ____________________ **Date:** ______________ .

	CRITERION	RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)
S7	INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT: one or more members of the ACT Team provide direct treatment and substance abuse treatment for clients with substance use disorders.	No direct, individualized substance abuse treatment is provided by the team.	The team variably addresses SA concerns with clients; no formal, individualized SA treatment provided.	While the team integrates some substance abuse treatment into regular client contact, they provide no formal, individualized SA treatment.	Some formal individualized SA treatment is offered; clients with substance use disorders spend less than 24 minutes/week in such treatment.	Clients with substance use disorders spend, on average, 24 minutes / week or more in formal substance abuse treatment.
S8	DUAL DISORDER TREATMENT GROUPS: ACT Team uses group modalities as a treatment strategy for people with substance use disorders.	Fewer than 5% of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.	5 - 19%	20 - 34%	35 - 49%	50% or more of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.
S9	DUAL DISORDERS (DD) MODEL: ACT Team uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	ACT Team fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	ACT Team uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for motivation of clients in denial or who don't fit AA.	ACT Team uses mixed model: e.g., DD principles in treatment plans; refers clients to motivation groups; uses hospitalization for rehab.; refers to AA, NA.	ACT Team uses primarily DD model: e.g., DD principles in treatment plans; motivation and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some s/a treatment.	ACT Team fully based in DD treatment principles, with treatment provided by ACT Team staff.
S10	ROLE OF CONSUMERS ON TREATMENT TEAM: Consumers are involved as members of the team providing direct services.	Consumers have no involvement in service provision in relation to the ACT Team.	Consumer(s) fill consumer-specific service roles with respect to ACT Team (e.g., self-help).	Consumer(s) work part-time in case-management roles with reduced responsibilities.	Consumer(s) work full-time in case management roles with reduced responsibilities.	Consumer(s) are employed full-time as clinicians (e.g., case managers) with full professional status.