

Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale Version 1.0

NOTE: *This document represents only a summary of the TMACT items, definitions, and anchored ratings. A TMACT fidelity evaluation should not be completed without using the TMACT Protocol (Parts I and II) and Appendices.*

Monroe-DeVita, M., Moser, L.L. & Teague, G.B. (2013). *The tool for measurement of assertive community treatment (TMACT)*. In M. P. McGovern, G. J. McHugo, R. E. Drake, G. R. Bond, & M. R. Merrens. (Eds.), *Implementing evidence-based practices in behavioral health*. Center City, MN: Hazelden.

For questions regarding the TMACT, including training and consultation in administering this fidelity measure, contact:
Maria Monroe-DeVita, PhD: mmdv@uw.edu
Lorna Moser, PhD: lorna_moser@med.unc.edu OR
Gregory Teague, PhD: teague@usf.edu

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Operations and Structure (OS) Subscale						
OS1	LOW RATIO OF CONSUMERS TO STAFF: The team maintains a low consumer-to-staff ratio, not to exceed 10:1, which includes all direct service staff with the exception of the psychiatric care provider. The staff count also does NOT include other administrative staff such as the program assistant or other managers assigned to provide administrative oversight to the team.	26 consumers per team member or more.	19 – 25	14 – 18	11 – 13	10 consumers per team member or fewer.
OS2	TEAM APPROACH: ACT staff work as a transdisciplinary team rather than as individual practitioners; ACT staff know and work with all consumers. The entire team shares responsibility for each consumer; each clinician contributes expertise as appropriate.	Fewer than 25% of consumers have face-to-face contacts with at least 3 team members in 4 weeks.	25 – 52%	53 - 74%	75 - 89%	90% or more consumers have face-to-face contact with at least 3 team members in 4 weeks.
OS3	DAILY TEAM MEETING (FREQUENCY & ATTENDANCE): Team meets on a daily basis and all staff scheduled for that shift normally attend this meeting to review and plan service contacts with each consumer.	Team meets less than 2 days a week.	Team meets 2 days a week.	Team meets 3 days a week with full attendance OR team meets 4 days a week, but without full attendance.	Team meets 4 days a week with full attendance OR team meets 5 days a week, but without full attendance.	Team meets 5 days a week with full attendance.
OS4	DAILY TEAM MEETING (QUALITY): Team uses its daily team meeting to: (1) Conduct a brief, but clinically-relevant review of all consumers & contacts in the past 24 hours AND (2) record status of all consumers. Team develops a Daily Staff Schedule for the day's contacts based on: (3) Weekly Consumer Schedules, (4) emerging needs, AND (5) need for proactive contacts to prevent future crises; (6) Staff are held accountable for follow-through.	Daily team meeting serves no more than 3 functions.	4 functions are met at least PARTIALLY (2 functions are absent).	5 functions are met at least PARTIALLY (1 function is absent) OR ALL 6 functions are met with 4 or more PARTIALLY met.	ALL 6 functions met, with up to 3 PARTIALLY met.	ALL 6 daily team meeting functions FULLY met (see under definition).
OS5	PROGRAM SIZE: Team is of sufficient absolute size to consistently provide necessary staffing diversity and coverage. NOTE: This item includes separate parameters for minimal coverage for smaller teams in order to allow for enough staff to be available 24 hours a day, seven days a week.	100-Consumer Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 6.9 FTE	7.0 - 8.4 FTE	8.5 - 9.9 FTE	100-Consumer Team: Includes at least 10.0 FTE direct clinical staff.
		50-Consumer Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	50-Consumer Team: Includes at least 7.0 FTE direct clinical staff.
OS6	PRIORITY SERVICE POPULATION: ACT teams serve a specific, high-service need population of adults with serious mental illness and are in a position to make decisions about who is served by the team. (1) Team has specific admission criteria, inclusive of schizophrenia & other psychotic disorders or bipolar disorder, significant functional impairments, and continuous high service needs, and exclusive of a sole or primary diagnosis of a substance use disorder, mental retardation, brain injury or Axis II disorders. (2) Team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.	Team PARTIALLY meets criterion #2 only, OR does not meet either criterion.	Team PARTIALLY meets criterion #1 only.	Team PARTIALLY meets criterion #1, and at least PARTIALLY meets criterion #2.	Team FULLY meets criterion #1, and PARTIALLY meets criterion #2.	Team FULLY meets both criteria (see under definition).

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Operations and Structure (OS) Subscale (cont.)						
OS7	ACTIVE RECRUITMENT: (1) Team (or its organizational representative) actively recruits new consumers who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team. (2) Team is primarily comprised of consumers from common referral sources and sites outside of usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach). (3) Team works to fill open slots when they are not at full capacity and/or the staff-to-consumer ratio is well below 1:10 on more mature teams.	Team PARTIALLY meets 1 criterion or less.	1 criterion FULLY met (2 criteria not met at all) OR 2 criteria at least PARTIALLY met (1 criterion is absent).	2 criteria FULLY met (1 criterion not met at all) OR ALL 3 criteria met, with 2 or 3 PARTIALLY met.	ALL 3 criteria met, with 2 FULLY and 1 PARTIALLY met.	ALL 3 criteria FULLY met (see under definition).
OS8	GRADUAL ADMISSION RATE: The team takes consumers in at a low rate to maintain a stable service environment.	Highest monthly admission rate in the last 6 months is greater than 15 consumers per month.	12 -15	8 - 11	5 - 7	Highest monthly admission rate in the last 6 months no greater than 4 consumers per month.
OS9	TRANSITION TO LESS INTENSIVE SERVICES: (1) Team conducts regular assessment of need for ACT services; (2) Team uses explicit criteria or markers for need to transfer to less intensive service option; (3) Transition is gradual & individualized, with assured continuity of care; (4) Status is monitored following transition, per individual need; and (5) There is an option to return to team as needed.	Team does not actively facilitate consumer transition to less intensive services OR 1 to 2 criteria met, at least PARTIALLY.	2 criteria FULLY met OR 3 criteria met, at least PARTIALLY.	3 criteria FULLY met OR 4 criteria met, at least PARTIALLY.	4 criteria FULLY met.	ALL 5 criteria FULLY met (see under definition).
OS10	RETENTION RATE: Team retains a high percentage of consumers given that they enroll consumers appropriate for ACT, utilize appropriate engagement techniques, and deliver individualized services. Referral to a more restrictive setting/program would normally be considered an adverse outcome.	Less than 65% of the caseload is retained over a 12-month period.	65 - 76%	77 – 86%	87 - 94%	95% or more of caseload is retained over a 12-month period.
OS11	INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the consumer (e.g., activating crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the consumer during his/her hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning).	Team has involvement in fewer than 15% of admissions & discharges.	Team is involved in 15% - 44% of admissions & discharges.	Team is involved in 45 - 69% of admissions & discharges.	Team is involved in 70% - 89% of admissions & discharges.	Team is involved in 90% or more admissions & discharges.
OS12	DEDICATED OFFICE-BASED PROGRAM ASSISTANCE: The team has 1.0 FTE of office-based program assistance available to facilitate the day's operations in a supportive manner to both team and consumers. Primary functions include: (1) providing direct support to staff, including monitoring & coordinating daily team schedules and supporting staff both in the office and field; (2) serving as a liaison between consumers and staff, such as attending to the needs of office walk-ins and calls from consumers/natural supports; and (3) actively participating in the daily team meeting.	Less than 0.50 FTE program assistance is available to the team OR 0.50 - 1.0 FTE program assistance is available, but not meeting anchor "2" performance.	0.50 - 0.99 FTE program assistance is available, performing 2 functions, at least PARTIALLY OR 1.0 FTE program assistance is available and performing 1 function ONLY.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing ALL functions OR 1.0 FTE program assistance is available, at least PARTIALLY performing #1-2 (no function #3).	1.0 FTE program assistance, at least PARTIALLY performing ALL functions.	1.0 FTE program assistance available, FULLY performing ALL functions.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Team (CT) Subscale						
CT1	<p>TEAM LEADER ON TEAM: The team has 1.0 full-time (i.e., works 40 hours a week) team leader with full clinical, administrative, and supervisory responsibility to the team. The team leader has no responsibility to any other programs during the 40-hour workweek. The team leader must have at least a Master's degree in social work, psychology, psychiatric rehabilitation, or a related clinical field, and a license in their respective field, and at least three years of experience in working with adults with severe mental illness. Team leader cannot fill more than one role on the team.</p>	<p>Less than 0.25 FTE team leader OR less than 1.0 full-time team leader with inadequate qualifications.</p>	<p>0.25 - 0.74 FTE team leader who meets at least minimal qualifications</p>	<p>0.75 - 1.0 FTE team leader who does not meet minimal qualifications.</p>	<p>0.75 – 0.99 FTE team leader who meets at least minimal qualifications OR 1.0 full-time team leader who meets all qualifications with the exception of having a clinical license.</p>	<p>1.0 full-time team leader, who meets at least minimal qualifications, including licensure, and has full assigned responsibility to the team.</p>
CT2	<p>TEAM LEADER IS PRACTICING CLINICIAN: In addition to providing administrative oversight to the team, the team leader performs the following functions: (1) directly providing services as a clinician on the team and (2) delivering consistent clinical supervision to ACT staff.</p>	<p>Neither direct clinical services nor clinical supervision are provided at a frequency meeting low-level standards, see Table 9.</p>	<p>Low-level of frequency for both direct clinical services and clinical supervision OR One practice is not provided.</p>	<p>Both practices provided at moderate-level of frequency OR One practice provided at a high- or moderate-level, and one at a low-level of frequency.</p>	<p>One practice is provided at a moderate-level, and one practice is at a high-level of frequency.</p>	<p>High-level of frequency for both direct clinical services and clinical supervision (see definitions and Table 9).</p>
CT3	<p>PSYCHIATRIC CARE PROVIDER ON TEAM: The team has at least 0.8 FTE psychiatric care provider time to directly work with a 100-consumer team. Minimal qualifications include the following: (1) qualified by state law to prescribe medications; (2) Board certified in psychiatry/mental health by a national certifying body recognized & approved by the state licensing entity; and (3) has relevant experience working with people with serious mental illness.</p>	<p>Less than 0.2 FTE psychiatric care provider(s) per 100 consumers.</p>	<p>0.20- 0.30 FTE psychiatric care provider meeting at least minimal qualifications per 100 consumers with demonstrated communication and collaboration if multiple providers. OR Criteria for a "3" rating met, except communication standard if two or more providers, or inadequate qualifications cited.</p>	<p>0.40- 0.50 FTE psychiatric care provider meeting at least minimal qualifications per 100 consumers with demonstrated communication and collaboration if multiple providers. OR Criteria for a "4" rating met, except communication standard if two or more providers.</p>	<p>0.60- 0.79 FTE psychiatric care provider meeting at least minimal qualifications per 100 consumers with demonstrated communication and collaboration if multiple providers. OR Criteria for a "5" rating met, except communication standard if two or more providers.</p>	<p>At least 0.8 FTE psychiatric care provider meeting at least minimal qualifications per 100 consumers. Two or more providers must demonstrate a mechanism for adequate communication & collaboration between providers.</p>

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Team (CT) Subscale (cont.)						
CT4	<p>ROLE OF PSYCHIATRIC CARE PROVIDER IN TREATMENT: In addition to providing psychopharmacologic treatment, the psychiatric care provider performs the following functions in treatment: (1) <i>Typically</i> provides at least monthly assessment and treatment of consumers' symptoms and response to the medications, including side effects; (2) Provides brief therapy; (3) Provides diagnostic and medication education to consumers, with medication decisions based in a shared decision making paradigm; (4) Monitors all consumers' non-psychiatric medical conditions and non-psychiatric medications; (5) If consumers are hospitalized, communicates directly with consumers' inpatient psychiatric care provider to ensure continuity of care; and (6) Conducts home and community visits.</p>	Psychiatric care provider performs 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (i.e., 1 is absent) OR ALL 6 functions are performed, but more than 2 are PARTIALLY performed.	ALL 6 functions are performed, but up to 2 functions are only PARTIALLY provided.	ALL 6 treatment functions FULLY performed (see under definition).
CT5	<p>ROLE OF PSYCHIATRIC CARE PROVIDER WITHIN TEAM: The psychiatric care provider performs the following functions WITHIN THE TEAM: (1) Collaborates with the team leader in sharing overall clinical responsibility for monitoring consumer treatment and team member service delivery; (2) Educates non-medical staff on psychiatric and non-psychiatric medications, their side effects, and health-related conditions; (3) Attends majority of treatment planning meetings; (4) Attends daily team meetings in proportion to time allocated on team; (5) Actively collaborates with nurses; and (6) Provides psychiatric back-up to the program after-hours and weekends (NOTE: may be on a rotating basis as long as other psychiatric care providers who share on-call have access to consumers' current status and medical records/current medications).</p>	Psychiatric care provider performs no more than 2 team functions total.	3 team functions are performed.	4 team functions are performed.	5 team functions are performed.	ALL 6 team functions are performed (see under definition).
CT6	<p>NURSES ON TEAM: The team has at least 2.85 FTE Registered Nurses (RNs) assigned to work within a 100-consumer team. At least one full-time RN on the team has a minimum of one year experience working with adults with severe mental illness. NOTE: This item is rated based on 2.85 FTE (vs. 3.0 FTE) since there is more likelihood for the team to get penalized on this particular item if the census goes even slightly above the 100-consumer team.</p>	Less than 0.50 FTE RNs per 100 consumers.	0.50 - 1.40 FTE RNs per 100 consumers.	1.41 - 2.10 FTE RNs per 100 consumers OR No full-time RNs have a minimum of 1 year experience working with adults with severe mental illness.	2.11 - 2.84 FTE RNs per 100 consumers.	At least 2.85 FTE Registered Nurses (RNs) per 100-consumer team (see under definition); at least 1 full-time nurse must have at least 1 year experience working with adults with SMI. If not, rate no higher than a "3").
CT7	<p>ROLE OF NURSES: Team nurses perform the following critical roles (in collaboration with the psychiatric care provider): (1) manage the medication system, administer & document medication treatment; (2) screen and monitor consumers for medical problems/side effects; (3) communicate & coordinate services with the other medical providers; (4) engage in health promotion, prevention, & education activities (i.e., assess for risky behaviors & attempt behavior change); (5) educate other team members to help them monitor psychiatric symptoms & medication side effects; & (6) when consumers are in agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).</p>	Nurses perform 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (i.e., 1 is absent) OR ALL 6 functions are performed, but more than 2 are PARTIALLY performed.	ALL 6 functions, with up to 3 functions PARTIALLY performed.	ALL 6 functions FULLY performed (see under definition).

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Specialist Team (ST) Subscale						
ST1	SUBSTANCE ABUSE SPECIALIST ON TEAM: The team has at least 1.0 FTE team member designated as a substance abuse specialist, who has at least a bachelor's degree and meets local standards for certification as a substance abuse or co-occurring specialist. Preferably this specialist has training or experience in integrated dual disorders treatment.	Less than 0.25 FTE substance abuse specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist)) OR Criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 FTE substance abuse specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist)) OR Criteria for a "3" rating met, except qualifications standards.	0.5 - 0.74 FTE substance abuse specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist)) OR Criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 FTE substance abuse specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist)) OR Criteria for a "5" rating met, except qualifications standards.	At least 1.0 FTE substance abuse specialist with at least minimal qualifications. At least 80% of consumer contacts involve specialist-related activities (vs. generalist).
ST2	ROLE OF SUBSTANCE ABUSE SPECIALIST IN TREATMENT: The substance abuse specialist provides integrated dual disorders treatment to ACT consumers who have a substance use problem. Core services include: (1) conducting comprehensive substance use assessments that consider the relationship between substance use and mental health; (2) assessing and tracking consumers' stages of change readiness and stages of treatment; (3) using outreach and motivational interviewing techniques; (4) using cognitive behavioral approaches and relapse prevention; and (5) applying treatment approaches consistent with consumers' stage of change readiness.	Substance abuse specialist provides 1 or fewer dual disorders services.	2 dual disorders services provided (i.e., 3 services are absent).	3-4 dual disorders services are provided, (i.e., 1 or 2 services are absent) OR ALL 5 services are provided, with 3 or more PARTIALLY provided.	ALL 5 dual disorders services, but up to 2 services are only PARTIALLY provided.	ALL 5 dual disorders services FULLY provided (see under definition).
ST3	ROLE OF SUBSTANCE ABUSE SPECIALIST WITHIN TEAM: The substance abuse specialist is a key team member in the service planning for consumers with dual disorders. The substance abuse specialist performs the following functions WITHIN THE TEAM: (1) modeling skills and consultation; (2) cross-training to other staff on the team to help them develop dual disorders assessment and treatment skills; (3) attending all daily team meetings; and (4) attending all treatment planning meetings for consumers with dual disorders.	Substance abuse specialist does not perform any of the 4 functions within the team.	1 function performed within the team.	2 functions performed within the team.	3 functions performed within the team.	ALL 4 functions performed within the team (see under definition).
ST4	VOCATIONAL SPECIALIST ON TEAM: The team has at least 1.0 FTE team member designated as a vocational specialist, with at least one year of experience providing employment services (e.g., job development, job coaching, supported employment). Ideally, the ACT vocational specialist is a part of a larger supported employment program within the agency.	Less than 0.25 FTE vocational specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist)) OR Criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 FTE vocational specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist)) OR Criteria for a "3" rating met, except qualifications standards.	0.5 - 0.74 FTE vocational specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist)) OR Criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 FTE vocational specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist)) OR Criteria for a "5" rating met, except qualifications standards.	At least 1.0 FTE vocational specialist with at least minimal qualifications. At least 80% of consumer contacts involve specialist-related activities (vs. generalist).

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Specialist Team (ST) Subscale (cont.)						
ST5	<p>ROLE OF VOCATIONAL SPECIALIST IN EMPLOYMENT SERVICES: The vocational specialist provides supported employment services. Core services include: (1) engagement; (2) vocational assessment; (3) job development; (4) job placement (including going back to school, classes); (5) job coaching & follow-along supports (including supports in academic settings); and (6) benefits counseling.</p>	The vocational specialist provides 2 or fewer employment services.	<p>3 employment services are provided (i.e., 3 services are absent)</p> <p>OR</p> <p>4 services are PARTIALLY provided (2 are absent).</p>	<p>4 employment services are provided (i.e., 2 services are absent), but up to 3 services are only PARTIALLY provided OR 5 employment services are provided (i.e., 1 service is absent) OR ALL 6 services are provided, with 4 or more PARTIALLY provided.</p>	ALL 6 employment services are provided, but up to 3 services are only PARTIALLY provided.	ALL 6 employment services are FULLY provided (please see the definition).
ST6	<p>ROLE OF VOCATIONAL SPECIALIST WITHIN TEAM: The vocational specialist is a key team member in the service planning for consumers who want to work or are currently working. The vocational specialist performs the following functions WITHIN THE TEAM: (1) modeling skills and consultation; (2) cross-training to other staff on the team to help them to develop supported employment approaches with consumers in the team; (3) attending all daily team meetings; and (4) attending all treatment planning meetings for consumers with employment goals.</p>	Vocational specialist does not perform any of the 4 functions within the team.	1 function performed within the team.	2 functions performed within the team.	3 functions performed within the team.	ALL 4 functions performed within the team (see under definition).
ST7	<p>PEER SPECIALIST ON TEAM: The team has at least 1.0 FTE team member designated as a peer specialist who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following: (1) self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) is in the process of his/her own recovery; and (3) has successfully completed training in wellness and recovery interventions.</p>	<p>Less than 0.25 FTE peer specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist))</p> <p>OR</p> <p>Criteria for a "2" rating met, except qualifications standards.</p>	<p>0.25 - 0.49 FTE peer specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist))</p> <p>OR</p> <p>Criteria for a "3" rating met, except qualifications standards.</p>	<p>0.5 - 0.74 FTE peer specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist))</p> <p>OR</p> <p>Criteria for a "4" rating met, except qualifications standards.</p>	<p>0.75 - 0.99 FTE peer specialist with at least minimal qualifications (see definition for how to calculate adjusted FTE if less than 80% of consumer contacts involve specialist-related activities (vs. generalist))</p> <p>OR</p> <p>Criteria for a "5" rating met, except qualifications standards.</p>	<p>At least 1.0 FTE peer specialist with at least minimal qualifications.</p> <p>At least 80% of consumer contacts involve specialist-related activities (vs. generalist).</p>
ST8	<p>ROLE OF PEER SPECIALIST: The peer specialist performs the following functions: (1) coaching and consultation to consumers to promote recovery and self-direction (e.g., preparation for role in treatment planning meetings); (2) facilitating wellness management and recovery strategies (e.g., Wellness Recovery Action Plans (WRAP), Illness Management and Recovery (IMR), or other deliberate wellness strategies); (3) participating in all team activities (e.g., treatment planning, chart notes) equivalent to fellow team members; (4) modeling skills for and providing consultation to fellow team members; and (5) providing cross-training to other team members in recovery principles and strategies.</p>	Peer specialist performs 1 or fewer functions on the team.	<p>2 functions FULLY performed</p> <p>OR</p> <p>2 to 3 functions PARTIALLY.</p>	<p>3 functions FULLY performed</p> <p>OR</p> <p>4 to 5 functions PARTIALLY.</p>	4 functions FULLY performed	ALL 5 functions FULLY performed (see under definition).

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Practices (CP) Subscale						
CP1	COMMUNITY-BASED SERVICES: The team works to monitor status and develop skills in the community, rather than in office. Team is oriented to bringing services to the consumer, who, for various reasons, has not effectively been served by office-based treatment.	Less than 40% of face-to-face contacts in community.	40 - 54%	55 - 64%	65 - 74%	At least 75% of total face-to-face contacts in community.
CP2	ASSERTIVE ENGAGEMENT MECHANISMS: The team uses an array of techniques to engage difficult-to-treat consumers. These techniques include: (1) collaborative, motivational interventions to engage consumers and build intrinsic motivation for receiving services from the team, and, where necessary, (2) therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to consumers or others. When therapeutic limit-setting interventions are used, there is a focus on instilling autonomy as quickly as possible. In addition to being proficient in a range of engagement interventions, (3) the team has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of chosen techniques, and modifying approach when indicated.	Very little assertive engagement is evident (#1, #2, and #3 largely absent).	Team primarily relies on #1 OR #2, not both (1 approach is FULLY or PARTIALLY used and 1 is not used at all (No Credit)). #3 is absent.	A more limited array of assertive engagement strategies are used (PARTIAL #1 and #2). Thoughtful application/ withdrawal of engagement strategies is significantly lacking or absent (#3 is absent).	Team uses #1 and #2 (at least 1 approach is FULLY used). Thoughtful application/ withdrawal of engagement strategies is significantly lacking or absent (#3 is absent).	Team is proficient in assertive engagement strategies, applying all 3 practices (see under definition).
CP3	INTENSITY OF SERVICE: The team provides 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 consumer.	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 consumer.
CP4	FREQUENCY OF CONTACT: The team delivers high number of face-to-faceservice contacts as needed.	Average of less than 0.5 face-to-face contacts / week or fewer per consumer.	0.6 - 1.3 / week.	1.4 - 2.1 / week.	2.2 - 2.9 / week.	Average of 3 or more face-to-face contacts / week per consumer.
CP5	FREQUENCY OF CONTACT WITH NATURAL SUPPORTS: The team has access to consumers' natural supports. These supports either already existed, and/or resulted from the team's efforts to help consumers develop natural supports. Natural supports include people in the consumer's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy).	For less than 25% of consumers, the natural support system is contacted by team at least 1 time per month.	26% - 50%	51% - 75%	76% -89%	For at least 90% of consumers, the natural support system is contacted by team at least 1 time per month.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Practices (CP) Subscale (cont.)						
CP6	<p>RESPONSIBILITY FOR CRISIS SERVICES: The team has 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria: 1) The team is available to consumers in crisis 24 hours a day, 7 days a week; 2) The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging); 3) The team accesses practical, individualized crisis plans to help them address crises for each consumer; and 4) The team is able and willing to respond to crises in person, when needed.</p>	Team has no responsibility for directly handling crises after-hours.	Team meets up to 2 criteria at least PARTIALLY .	Team meets Criterion #1 and PARTIALLY meets 2 to 3 criteria.	Team meets 3 criteria FULLY and 1 PARTIALLY .	Team FULLY meets all 4 criteria (see under definition).
CP7	<p>FULL RESPONSIBILITY FOR PSYCHIATRIC SERVICES: The team assumes responsibility for providing psychiatric services to consumers, where there is little need for consumers to have to access such services outside of the team. The psychiatric care provider assumes most of the responsibility for psychiatric services. However, the team's role in medication administration and monitoring are also considered in this assessment, especially when evaluating psychiatric services provided to consumers residing in supervised settings where non-ACT staff also manage medications; the expectation is that ACT staff play an active role in monitoring medication management even when a consumer is in a residential setting.</p>	Less than 20% of consumers in need of psychiatric services are receiving them from the team.	20 - 49% of consumers in need of psychiatric services are receiving them from the team.	50 - 74% of consumers in need of psychiatric services are receiving them from the team.	75 - 89% of consumers in need of psychiatric services are receiving them from the team.	90% or more of consumers in need of psychiatric services are receiving them from the team.
CP8	<p>FULL RESPONSIBILITY FOR PSYCHIATRIC REHABILITATION SERVICES: The team assumes responsibility for providing psychiatric rehabilitation services to consumers, where there is little need for consumers to have to access such services outside of the team. Psychiatric rehabilitation services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration). Psychiatric rehabilitation should address functional deficits as well as the lack of necessary resources, all of which are identified through the assessment process. As such, deliberate and consistent skills training which typically includes staff demonstration, consumer practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings.</p>	Less than 20% of consumers in need of psychiatric rehabilitation services are receiving them from the team.	20 - 49% of consumers in need of psychiatric rehabilitation services are receiving them from the team.	50 - 74% of consumers in need of psychiatric rehabilitation services are receiving them from the team.	75 - 89% of consumers in need of psychiatric rehabilitation services are receiving them from the team.	90% or more of consumers in need of psychiatric rehabilitation services are receiving them from the team.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Evidence-Based Practices (EP) Subscale						
EP1	FULL RESPONSIBILITY FOR DUAL DISORDERS TREATMENT: The team assumes responsibility for providing dual disorders (DD) treatment to consumers, where there is little need for consumers to have to access such services outside of the team. Core services include systematic and integrated screening and assessment and interventions tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing) and later stages of change readiness (e.g., CBT, relapse-prevention).	Less than 20% of consumers in need of dual disorders treatment are receiving them from the team.	20 - 49% of consumers in need of dual disorders treatment are receiving them from the team.	50 - 74% of consumers in need of dual disorders treatment are receiving them from the team.	75 - 89% of consumers in need of dual disorders treatment are receiving them from the team.	90% or more of consumers in need of dual disorders treatment are receiving them from the team.
EP2	FULL RESPONSIBILITY FOR VOCATIONAL SERVICES: The team assumes responsibility for providing vocational services to consumers, where there is little need for consumers to have to access such services outside of the team. Core services include engagement, vocational assessment, job development, job placement (including going back to school, classes), and job coaching & follow-along supports (including supports in academic/school settings).	Less than 20% of consumers in need of vocational services are receiving them from the team.	20 - 49% of consumers in need of vocational services are receiving them from the team.	50 - 74% of consumers in need of vocational services are receiving them from the team.	75 - 89% of consumers in need of vocational services are receiving them from the team.	90% or more of consumers in need of vocational services are receiving them from the team.
EP3	FULL RESPONSIBILITY FOR WELLNESS MANAGEMENT AND RECOVERY SERVICES: The team assumes responsibility for providing wellness management and recovery (WMR) services to consumers, where there is little need for consumers to have to access such services outside of the team. These services include a formal and/or manualized approach to working with consumers to build and apply skills related to their recovery. Examples of such services include the development of Wellness Recovery Action Plans (WRAP) and provision of the Illness Management and Recovery (IMR) curriculum.	Less than 20% of consumers in need of wellness management and recovery services are receiving them from the team.	20 - 49% of consumers in need of wellness management and recovery services are receiving them from the team.	50 - 74% of consumers in need of wellness management and recovery services are receiving them from the team.	75 - 89% of consumers in need of wellness management and recovery services are receiving them from the team.	90% or more of consumers in need of wellness management and recovery services are receiving them from the team.
EP4	INTEGRATED DUAL DISORDERS TREATMENT (IDDT) MODEL: The FULL TEAM uses a stage-wise treatment model that is non-confrontational and the FULL TEAM: (1) considers interactions between mental illness and substance abuse; (2) does not have absolute expectations of abstinence and supports harm reduction; (3) understands and applies stages of change readiness in treatment; (4) is skilled in motivational interviewing; and (5) follows cognitive-behavioral principles.	Team primarily uses traditional model. (e.g., 12-step programming, a focus on abstinence). Criteria not met.	Only 1 - 3 criteria are met.	4 or 5 criteria are met at least PARTIALLY.	Team primarily operates from IDDT model, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team is fully based in IDDT treatment principles, FULLY meeting all 5 criteria (see under definition).

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Evidence-Based Practices (EP) Subscale (cont.)						
EP5	SUPPORTED EMPLOYMENT (SE) MODEL: The FULL TEAM: (1) values competitive work as a goal for all consumers, and believes that: (2) a consumer's expressed desire to work is the only eligibility criterion for SE services; (3) on-the-job assessment is more valuable than extensive prevocational assessment; (4) placement should be individualized and tailored to a consumer's preferences; and (5) ongoing supports and job coaching should be provided when needed and desired by consumer.	Team does not embrace supported employment model.	Only 1 - 3 criteria are met.	4 or 5 criteria are met at least PARTIALLY	Team primarily embraces SE model, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team fully embraces SE model and FULLY meets all 5 criteria (see under definition).
EP6	ENGAGEMENT & PSYCHOEDUCATION WITH NATURAL SUPPORTS: The FULL TEAM works in partnership with consumers' natural supports. As part of their active engagement of natural supports, the team: (1) provides education about their loved one's illness; (2) teaches problem-solving strategies for difficulties caused by illness; and (3) provides &/or connects natural supports with social & support groups.	Team does not use any of the specified strategies with consumers' natural supports.	1 or 2 strategies used.	ALL 3 strategies used, but 2-3 strategies only PARTIALLY.	ALL 3 strategies used but 1 only PARTIALLY.	ALL 3 strategies FULLY used by team (see under definition).
EP7	EMPIRICALLY-SUPPORTED PSYCHOTHERAPY: The team: (1) deliberately provides individual and/or group psychotherapy, as specified in the treatment plan; (2) uses empirically-supported techniques to address specific symptoms and behaviors; and (3) maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to consumers in need of such services. Ideally, psychotherapy is conducted by a trained therapist.	Team does not provide psychotherapy to consumers.	Team meets only 1 criterion.	Team meets criteria #1 and #2, but does not meet criterion #3	Team meets criteria #1 and #2 and only PARTIALLY meets criterion #3.	Team FULLY meets all three criteria (see under definition).
EP8	SUPPORTIVE HOUSING MODEL: The team embraces the supportive housing model, including: 1) assisting consumers in locating housing of their choice (e.g., providing multiple housing options, including integrated housing); 2) respect for consumers' privacy within residence; 3) assistance in accessing affordable, safe/decent, and permanent housing; and 4) assured ongoing tenancy rights, regardless of consumers' progress or success in ACT services.	Team meets no more than 1 criterion.	3 criteria PARTIALLY met OR 2 criteria met, at least PARTIALLY.	4 criteria met, with at least 2 PARTIALLY met OR 3 criteria met, with at least 1 criterion FULLY met.	ALL 4 criteria met, with up to 1 criterion PARTIALLY met (remaining 3 criteria are FULLY met).	ALL 4 criteria FULLY met.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Person-Centered Planning & Practices (PP) Subscale						
PP1	<p>STRENGTHS INFORM TREATMENT PLAN: 1) The team is oriented toward consumers' strengths and resources, and 2) consumers' strengths and resources inform treatment planning development.</p>	Strengths are not assessed (No Criteria #1 or #2).	Team attends to consumers' strengths and resources, but less systematically, and strengths/resources do not inform planning (Partial #1 only).	<p>Team is clearly attentive to consumers' strengths and resources, documenting such in plans, but consumers' strengths and resources do not typically inform plan development (Full #1 and No credit #2) OR</p> <p>Team is attentive to strengths and uses this information to inform plans, but less systematically (Partial #1 and Partial #2).</p>	Team is clearly attentive to consumers' strengths and resources, documenting such in plans, and consumers' strengths and resources inform plan development for some (Full #1 and Partial #2).	Team is highly attentive to consumers' strengths and resources, and gathers such information for the purpose of treatment planning (Full #1 and Full #2).
PP2	<p>PERSON-CENTERED PLANNING : The team conducts treatment planning according to the ACT model, using a person-centered approach, including: (1) development of formative treatment plan ideas based on initial inquiry and discussion with the consumer (prior to the formal treatment planning meeting); (2) conducting regularly scheduled treatment planning meetings; (3) attendance by key staff, the consumer, and anyone else s/he prefers (e.g., family), tailoring number of participants to fit with the consumer's preferences; (4) meeting driven by the consumer's goals and preferences; and (5) provision of guidance and support to promote self-direction and leadership within the meeting, as needed. For teams that use an Individual Treatment Team (ITT), treatment planning meetings should include members from this group.</p>	No more than 1 element of person-centered planning OR 2 elements provided, but both are not fully provided.	2 elements of person-centered planning are FULLY provided OR 3 elements are provided at least PARTIALLY.	4 elements of person-centered planning provided (i.e., 1 absent) OR provides 5 elements, with 3 or more PARTIALLY provided.	ALL 5 elements of person-centered planning are met, with up to 2 PARTIALLY provided.	ALL 5 elements of person-centered planning are FULLY provided (see under definition).
PP3	<p>INTERVENTIONS TARGET A BROAD RANGE OF LIFE DOMAINS: The team attends to a range of life domains (e.g., physical health, employment/education, housing satisfaction, legal problems) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in treatment plans and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to consumers' needs.</p>	The team does not plan for and/or deliver interventions that reflect a breadth of life domains.	<p>Team minimally plans for and/or delivers interventions that reflect life domains (PARTIAL credit for one criterion only) OR</p> <p>Team plans for but does not deliver a breadth of services (Full #1 only).</p>	<p>Team plans for and delivers interventions that reflect a breadth of life domains, but less systematically (PARTIAL #1 and PARTIAL #2) OR</p> <p>a larger breadth of services are planned for, but not in turn delivered (FULL #1 and PARTIAL #2).</p>	<p>Team delivers interventions that reflect a range of life domains to all consumers (FULL #2), but interventions targeting a breadth of life domains are not systematically specified in treatment plans (PARTIAL #1 OR FULL #1, but lacking Symmetry—see under definition).</p>	<p>Team specifies interventions that target a range of life domains in treatment plans and these interventions are carried out in practice (FULL criteria #1 and #2 with Symmetry - see under definition).</p>
PP4	<p>CONSUMER SELF-DETERMINATION & INDEPENDENCE: The team promotes consumers' independence and self-determination by: (1) helping consumers develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching consumers the skills required for independent functioning. The team recognizes the varying needs and functioning levels of consumers; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.</p>	<p>None of the 3 practices are employed OR</p> <p>Only 1 is employed (FULLY or PARTIALLY). Team provides a high level of supervision, directs consumer decisions, manages their day-to-day activities, and/or does not teach consumers skills to foster independence.</p>	2 practices are employed (FULLY or PARTIALLY), with one absent.	3 practices are employed, with 2 to 3 PARTIALLY.	Team generally promotes consumers' self-determination and independence. All 3 practices are employed, but 1 PARTIALLY employed.	Team is a strong advocate for consumers' self-determination and independence. All 3 practices are FULLY employed.