Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT **Provision of Assertive Community Treatment to Adult MHRS Consumers**		
POLICY NUMBER **340.6B**	**DATE** **08/23/2023** AUG 2 3 2023	**TL#** 340

Purpose. To delineate policies, procedures, and practice guidelines in the implementation of Assertive Community Treatment (ACT) to adult consumers in Mental Health Rehabilitation Services (MHRS). This policy has been updated to: (1) align the policy with updated regulatory requirements; (b) require that providers adhere to the Daily Living Assessment-20 (DLA-20) as the Department of Behavioral Health's (DBH) functional assessment tool; and (3) require that ACT providers adhere to the Tool for the Measurement of ACT (TMACT) as DBH's designated ACT fidelity monitoring tool.

Applicability. Applies to DBH, MHRS providers that serve adults, and ACT Providers.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate DBH offices.

Effective Date. This policy shall be effective August 23, 2023.

Superseded Policy. 340.6, Provision of Assertive Community Treatment to MHRS Adult Consumers.

Distribution. This policy will be posted on the DBH website at www.dbh.dc.gov under Policies, Rules and Bulletins. Applicable entities must ensure that affected staff are familiar with the contents of this policy.

Barbara J. Bazron, Ph.D.
Director, DBH

Barbara J Bazron 08/23/2023

(Signature) **(Date)**

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH	Policy No. 340.6B	Date AUG 2 3 2023 08/23/2023	Page 1
	Supersedes 340.6, Provision of Assertive Community Treatment to Adult MHRS Consumers, May 8, 2014		

Subject: Provision of Assertive Community Treatment (ACT) to Adult MHRS Consumers

1. **Purpose**.

To delineate policies, procedures, and practice guidelines in the implementation of Assertive Community Treatment (ACT) to adult consumers in Mental Health Rehabilitation Services (MHRS). This policy has been updated to: (1) align the policy with updated regulatory requirements; (b) require that providers adhere to the Daily Living Assessment-20 (DLA-20) as the Department of Behavioral Health's (DBH) functional assessment tool; and (3) require that ACT providers adhere to the Tool for the Measurement of ACT (TMACT) as DBH's designated ACT fidelity monitoring tool.

2. **Applicability**.

Applies to DBH, MHRS providers that serve adults, and ACT Providers.

3. **Authority**.

Department of Behavioral Health Establishment Act of 2013 (D.C. Code §§ 7-1141.01 *et seq.*) and Title 22-A DCMR Chapter 34, MHRS Provider Certification Standards.

4. **Key Terms and Definitions**

Assertive Community Treatment (ACT). An intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness.

ACT Providers. Agencies certified by DBH to provide ACT services consistent with Title 22-A DCMR Chapter 34.

ACT Team. The community-based inter-disciplinary team of qualified practitioners and other staff involved in providing ACT services to a consumer.

Daily Living Activities-20 (DLA-20). DBH's designated functional assessment tool for adult MHRS providers. The DLA-20 assesses twenty (20) areas of daily living that may be impacted by a consumer's mental illness or disability.

Tool for Measurement of ACT (TMACT). A contemporary evaluation tool used to assess how well a program is implementing critical elements of ACT.

5. **Policy**.

5a. DBH shall utilize ACT services to support adult consumers with serious and persistent mental illness who meet the ACT eligibility criteria.

5b. DBH shall respect consumer strengths and negotiable preferences in the delivery of ACT services, and develop interventions that best facilitate consumer recovery. ACT providers shall deliver least sixty percent (60%) percent of ACT services in community settings, including but not limited to at a consumer's residence.

5c. DBH shall adhere to the TMACT to measure the adequacy of each provider's ACT implementation and identify areas for improvement. ACT startup teams shall implement a baseline fidelity assessment using the TMACT.

5d. ACT teams shall follow the requirements outlined in the ACT Practice Guidelines (*see* Exhibit 1) to refer consumers toward ACT services. To qualify initially for ACT services, a consumer must have a DLA-20 score of four (4) or lower. To qualify for re-authorization of ACT services, a consumer must have a DLA-20 score of four (4) or lower. *See* Exhibit 2.

6. **Responsibilities**.

6a. DBH-certified providers must complete the ACT referral for a consumer that meets criteria for ACT in the payer's electronic system.

6b. The ACT authorizing entity shall:

(1) Review the referral form;

(2) If the consumer meets ACT criteria, provide authorization for ACT services; and

(3) Assign the consumer to an ACT Team.

6c. CSAs shall work collaboratively with the consumer and the ACT Team to ensure continuity of care upon admission, reactivation, and discharge from ACT services.

6d. All ACT Providers shall:

(1) Implement all governing requirements in Title 22-A DCMR Chapter 34, applicable bulletins, policies and guidance related to the provision of ACT services.

(2) Accept and engage all consumers authorized for ACT services within forty-eight (48) hours of assignment to an ACT Team.

(3) Hold team meetings daily to review and discuss consumer progress, the previous day's activities, assignment of new activities, and other ongoing concerns.

(4) Screen consumers for co-occurring disorders (substance use and medical) and initiate an integrated assessment and treatment intervention as indicated.

(5) Provide services twenty-four (24) hours a day, seven (7) days a week including after hours on weekends and holidays.

(6) Provide the full array of services and supports required by enrolled consumers to support mental health rehabilitation and stabilization.

(7) Ensure continuity of services for persons entering or leaving ACT as specified in Section 8 of this policy.

(8) Attend monthly DBH ACT Provider meetings.

(9) Submit monthly and other programmatic reports as required by DBH.

(10) Engage with the consumer to identify suitable and meaningful daily activities and facilitate the consumer's participation in those activities.

(11) Ensure that all ACT Teams have sufficient staffing to comply with TMACT and Title 22-A DCMR Chapter 34.

(12) Deliver ACT services in adherence to the TMACT fidelity tool averaging an annual score of three (3) or higher.

7. **Authorization for ACT Services**.

Prior authorization is required for enrolment in ACT services and re-authorization is required for continued treatment. Providers must submit requests for and changes to ACT service authorizations through the payer's electronic authorization system, following guidance or requirements in applicable companion guides or authorization manuals.

8. **Continuity of Care for ACT Consumers**.

8a. Upon Initial Acceptance into ACT Services.

(1) There shall be a thirty (30) calendar day transition period allowing for a shared caseload between the consumer's CSA and the ACT Team, during which the CSA continues to provide some support services while the ACT Team begins to engage the consumer. The transition period may be extended on a case-by-case basis based on medical necessity and clinical presentation.

(2) The ACT Team and the CSA must jointly develop an Individual Plan of Care (IPC) with the consumer during the transition period, including notating the outcomes the consumer will achieve through ACT participation in the goals and interventions section. The ACT provider must document the services provided during transition period in the consumer's IPC.

(3) The CSA and the ACT Team must meet jointly with the consumer face-to-face at least three (3) times per week during the transition period.

8b. Upon Discharge from ACT Services:

(1) For all consumers referred from ACT services to a CSA, there shall be a thirty (30) calendar day transition period allowing for a shared caseload between the consumer's CSA and ACT Team. The transition period may be renewed on a case-by-case basis based on medical necessity and clinical presentation. During the transition period, the ACT Team shall continue to provide some services and supports while the CSA also engages the consumer.

(2) The CSA and ACT Team must jointly develop an IPC with the consumer during the transition period and document the services provided in the consumer's IPC.

9. **Training**.

DBH and provider staff shall receive training in the implementation of ACT fidelity to sustain on-going fidelity monitoring and quality improvement efforts.

10. **Sanction for Non-Compliance**.

Providers that fail to comply with this policy may be subject to adverse action in accordance with Title 22-A DCMR Chapter 34.

11. **Inquiries**.

Questions related to this policy should be addressed to the DBH ACT Coordinator.

12. **Exhibits**.

Exhibit 1 ACT Practice Guidelines
Exhibit 2 DLA-20 Guide
Exhibit 3 ACT Fidelity Scale (TMACT)

Approved By:

Barbara J. Bazron, Ph.D.
Director, DBH

Barbara J Bazron 08/23/2023
(Signature) **(Date)**

DBH POLICY 340.6B, PROVISION OF ACT TO ADULT MHRS CONSUMERS EXHIBIT 1: ACT PRACTICE GUIDELINES

Service Definition

Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, treatment and community-based service delivered by an interdisciplinary team to adults with serious and persistent mental illness. ACT services are provided to consumers in accordance with their Individual Recovery Plan. ACT teams require specific and dedicated staff to consumer ratios. Service coverage by the ACT team must have specific program hours and be available for crisis services twenty-four (24) hours per day seven (7) days per week. At least sixty percent (60%) of ACT services must be provided to the consumer in non-office settings in the community.

I. Admission Guidelines

Referral Requirements in ACT

1. Consumers must have an intractable, serious and persistent mental illness. Mental illness may co-occur with substance use disorder.

A. One or more items from #2-7 below

2. High use of acute psychiatric hospitalization as evidenced by two (2) or more of the following in a one (1) year period: (a) psychiatric hospital admission; (b) mental health contact with the Department of Fire and Emergency Medical Services; (c) CPEP visit; or (d) mobile crisis deployment.

3. Co-occurring substance use disorders of greater than six (6) months.

4. At least one (1) arrest or incarceration within the past six (6) months.

5. Chronically homeless: (a) one (1) year continuously homeless; (b) four (4) episodes of homelessness in three (3) years; or (c) residing in substandard housing.

6. Residing in an inpatient setting for more than three (3) months or supervised community residence but clinically assessed to be able to live more independently with increased community-based services.

7. Documented inability to sustain involvement with or remain engaged in traditional office-based services.

B. One or more items from #1-3 below

1. Significant difficulty consistently performing the range of daily living tasks required to live in the community.

2. Significant difficulty maintaining consistent employment.

3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing, or being burglarized or robbed due to mental health instability).

C. Level of Care Assessment

DLA-20 score <= 3.1- 4.0

Information and Documentation Required for Referral

Multi-Axial Diagnosis
Psychosocial Summary
ACT Authorization Form
DLA-20 Score

II. Referral Process

1. Consumers requiring ACT services may be referred by/through their existing Core Services Agency (CSA), by themselves, by a personal advocate such as family member or friend, or by an institution or community-based agency.

2. A CSA must enter an authorization request into the payer authorization system of record.

3. All other referral sources must compile the information submit the information listed in Section I.2.C. to the consumer's CSA of record.

4. Once the authorization is approved and the ACT team is assigned, the ACT team must begin delivering services to the consumer within forty-eight (48) hours of referral.

5. CSAs must produce the following documentation to the ACT team within forty-eight (48) hours of referral upon the initiation of ACT: (a) the consumer's most recent doctor's notes including doctor's orders; (b) the consumer's recent progress notes; (c) the consumer's psychiatric and medical assessments; and (d) details about matters which may need to be addressed immediately.

6. The payer will notify the CSA and the ACT Team once the authorization is processed.

7. ACT teams do not have authority to deny authorizations or service delivery once the payer has authorized services and assigned the consumer to the ACT team.

8. CSAs must facilitate a thirty (30) calendar day transition period for each consumer upon the initiation of ACT services that must include a face-to-face meeting between both clinical teams and the consumer. This meeting may also include the referral source if different than the original clinical team.

9. The consumer or their representative may grieve the consumer's ACT eligibility determination by:

1) Requesting a review by the DBH ACT Coordinator;
2) Requesting a review by the DBH Chief Clinical Officer or designee; or
3) Filing a grievance pursuant to Title 22-A DCMR Chapter 3.

III. Discharge Process

DBH must approve all consumer discharges from ACT. ACT consumers will remain enrolled in ACT services during periods of hospitalization.

Consumer Name:
Consumer ID:

Daily Living Activities (©DLA-20): Adult Mental Health

Instructions: Using the scale below, rate how often or how well the consumer independently performed or managed each of the 20 Activities of Daily Living (ADLs) in the community during the last 30 days. If the consumer's level of functioning varied, rate the lower score. Consider impairments in functioning due to physical limitations as well as those due to mental impairments. Do not consider environmental limitations (e.g., "no jobs available"). Strengths are scored >=5 and indicate functioning "within normal limits" (WNL) for that activity. 20 scores are always applicable & valid for Average Composite DLA-20 to correlate with severity of illness index (SI)

1	2	3	4	5 (WNL)	6 (WNL)	7 (WNL)
None of the time; **extremely severe** impairment of problems in functioning, pervasive level of continuous paid supports needed	A little of the time; **severe** impairment or problems in functioning, extensive level of continuous paid supports needed	Occasionally, **serious** to moderately severe impairment or problems in functioning, moderate level of continuous paid supports needed	Some of the time; **moderate** impairment or problems in functioning; low level of continuous paid supports needed	A good bit of the time; **mild** impairment, challenge or problems in functioning, moderate level of intermittent paid supports needed	Most of the time; strength w/very mild impairment or problems in functioning; low level of intermittent paid supports needed	All of the time; independently managed DLA in community; no impairment or problem in functioning requiring paid supports

ACTIVITIES	Examples of scoring strengths as WNL behaviors (Scores 5-7) Dates:	Eval	R2	R3	R4	R5
1. Health Practices	Takes care of health issues, manages moods, infections; takes medication as prescribed; follows up on medical appointments.					
2. Housing Stability, Maintenance	Maintains stable housing; organizes possessions, cleans, abides by rules and contributes to maintenance if living with others					
3. Communication	Listens to people, expresses opinions/feelings; makes wishes know effectively.					
4. Safety	Safely moves about community – adequate vision, hearing, makes safe decisions. Safely uses small appliances, ovens/burners, matches, knives, razors, other tools.					
5. Managing Time	Follows regular schedule for bedtime, wake-up, mealtimes, rarely tardy or absent for work, day programs, appointments, scheduled activities.					
6. Managing Money	Manages money wisely (independent source of funds); controls spending habits.					
7. Nutrition	Eats at least 2 basically nutritious meals daily.					
8. Problem Solving	Resolves basic problems of daily living, asks questions for clarity and setting expectations.					
9. Family Relationships	Gets along with family, positive relationships as parent, sibling, child, significant other family member.					
10. Alcohol/Drug Use	Avoids abuse or abstains from alcohol/drugs, cigarettes; understands signs and symptoms of abuse or dependency; avoids misuse or combining alcohol, drugs, medication.					
11. Leisure	Relaxes with a variety of activities; attends/participates in sports or performing arts events; reads newspapers, magazines, books; recreational games with others; involved arts/crafts; goes to movies.					
12. Community Resources	Uses other community services, self-help groups, telephone, public transportation, religious organizations, shopping.					
13. Social Network	Gets along with friends, neighbors, coworkers, other peers.					
14. Sexuality	Appropriate behavior toward others; comfortable with gender, respects privacy and rights of others, practices safe sex or abstains.					
15. Productivity	Independently working, volunteering, homemaking, or learning skills for financial self-support.					
16. Coping Skills	Knows about nature of disability/illness, probable limitations, symptoms of relapse, behaviors that cause relapse or make situation/condition worse; makes plans and uses options for coping, improving, preventing relapse, restoring feelings of self-worth, competence, being in control.					
17. Behavior Norms	Complies with community norms, probation/parole, court requirements, if applicable; controls dangerous, violent, aggressive, bizarre, or nuisance behaviors; respects rights of others.					
18. Personal Hygiene	Cares for personal cleanliness, such as bathing, brushing teeth.					
19. Grooming	Cares for hair, hands, general appearance; shaves.					
20. Dress	Dresses self; wears clean clothes that are appropriate for weather, job, and other activities; clothing is generally neat and intact.					

Scoring Instructions: Step 1. Add 20 scores from current Review column (R1-R5).
Step 2. Divide sum by number of activities rated to obtain average DLA-20 composite score-keep 2 digits! No ADLs are N/A. Valid N=20 ADLs!
Step 3. To validate, use the DSM-5 count of serious disturbances per crosswalk or simply sum the number of ADLs rated <=3
Step 4: Consult the **crosswalk** for the ICD-10 Severity of Illness Index (SI)

Sum N=20 (max.140)					
Avg. Composite DLA-20					
DSM-5: # DLAs scored <=3					
Severity Index for ICD-10 Modifier					

Crosswalk from Average Composite DLA-20 to ICD-10 4th digit SI & DSM-5 # serious disturbances:
DLA-20 > 6.1 = Adequate Independence, no significant or slight impairment in functioning
ICD 10 4th digit modifier – 0 Severity - No difficulty means the person has no problem.

DLA-20: 5.10- 6.0 = Mild impairments, minimal interruptions in recovery
ICD 10 4th digit modifier = 1 Severity - Mild difficulty means problem is present less than 25 percent of the time with intensity a person can tolerate and happened rarely over the last 30 days.
DSM-5 # few and mild disturbances: max. 1 ADL may be scored = 3 "serious" but Severity=1
WHODAS 2.0 Self-report average score <=2
LOCUS (generally crosswalks) Level 1

DLA-20: 4.10- 5.0 = Moderate impairment in functioning
ICD 10 4th digit modifier = 2 Severity - Moderate difficulty means problem is present less than 50 percent of the time with moderate intensity that is interfering in the persons' day-to-day life and happened occasionally over the last 30 days.
DSM-5 "counts of serious disturbances": Total number ADLs scored =3, typically 1-3 disturbances
WHODAS 2.0 Self-report average score 3
LOCUS (generally crosswalks) Level 2 or ASAM Level 1

DLA-20: 3.10- 4.0 = Serious impairments in functioning
ICD 10 4th digit modifier = 3 Severity - Serious difficulty means problem is present more than 50 percent of the time with severe intensity that is partially disrupting the persons' day-to-day life and happened frequently over the last 30 days.
DSM-5 "counts of serious disturbances": Total number ADLs <= 3, typically 4-6 serious disturbances
WHODAS 2.0 Self-report average score 4
LOCUS (generally crosswalks) Level 3, ASAM 2

DLA-20: 2.10- 3.0 = Severe impairments in functioning
ICD 10 4th digit modifier =3 Severity - Severe difficulty means problem is present more than 75 percent of the time with severe intensity disrupting the persons' day-to-day life and happened frequently over the last 30 days.
DSM-5 "counts of serious disturbances": Total Number ADLs <=3, typically 7-10 serious disturbances
WHODAS 2.0 Self-report score >4 is severe distress, high risk.
LOCUS (generally crosswalks) Level 4

DLA-20: <= 2.0 Extremely severe impairments in functioning
ICD10 4th digit modifier = 4 Severity - Extremely severe indicates complete difficulty, a problem that is present more than 95 percent of the time with intensity that is totally disrupting the persons' day-to-day life and happened every day over the last 30 days.
Modified Global Assessment of Functioning (mGAF) identifies intensely high-risk behavior disturbances = 11 out of 20 ADLs scored <=3.

DLA-20© Scoring Rules

- Assess level of functioning or impairment compared to the entire population.
- Evaluation is based on the past 30 days.
- If functioning varied in the last 30 days, rate the lowest score on the more frequent pattern of behavioral responses to symptoms.
- Once you pick a number, look at the rating below to make sure a lower rating is not more accurate. Continue this until the most accurate rating is found.
- If you cannot decide between two scores, always choose the lower score.
- Consider impairments in functioning due to physical limitations as well as those due to mental impairments. Assess needs.
- Do not consider environmental limitations (e.g., "no jobs available").
- Must address at least 15 items.

The score is not necessarily correlated with the client's self-reported functioning as research shows —trust your own assessment of current behaviors, known and reported, and the anchors defining strengths & weaknesses compared to general population (not client population).

Program _____ Reviewer_____ Date_____

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

Version 1.0
Revision 3

February 28, 2018

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:
Lorna Moser, PhD: lorna_moser@med.unc.edu
Maria Monroe-DeVita, PhD: mmdv@uw.edu OR
Gregory Teague, PhD: teague@usf.edu

ITEM		RATINGS / ANCHORS				
	Operations and Structure (OS) Subscale	(1)	(2)	(3)	(4)	(5)
OS1	LOW RATIO OF CLIENTS TO STAFF: The team maintains a low client-to-staff ratio, not to exceed 10:1, which includes all direct service staff except for the psychiatric care provider. The staff count does NOT include other administrative staff such as the program assistant or other managers assigned to provide administrative oversight to the team.	26 clients per team member or more.	19 – 25	14 – 18	11 – 13	10 clients per team member or fewer.
OS2	TEAM APPROACH: ACT staff work as a transdisciplinary team rather than as independent team members; ACT staff know and work with all clients rather than carry individual caseloads. Although the entire team shares responsibility for each client, each team member contributes expertise as determined by client goals and needs identified in the person-centered plan, and carried out by each individual treatment team (ITT)).	Fewer than 25% of clients have face- to-face contacts with at least 3 team members in 4 weeks.	25 – 52%	53 - 74%	75 - 89%	90% or more clients have face- to-face contact with at least 3 team members in 4 weeks.
OS3	DAILY TEAM MEETING (FREQUENCY & ATTENDANCE): The team meets daily to review and plan services. To this end, most team members should be present to effectively carry out such a review. To constitute a daily team meeting, it must meet the following criteria: there is a review of each client's status; there is planning for future services; most team members are present.	Team meets fewer than 2 days a week.	Team meets 2 days a week.	Team meets 3 days a week with or without 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): The team uses its daily team meeting to: (1) Conduct a brief, but clinically-relevant review of all clients & contacts in the past 24 hours AND (2) Record the status of all clients. The team develops a daily staff schedule for the day's contacts based on: (3) Weekly/monthly client schedules, (4) Emerging needs, (5) Need for proactive contacts to prevent future crises; (6) Staff are held accountable for follow-through.	The daily team meeting serves no more than 3 functions.	4 functions are performed at least PARTIALLY (2 are absent).	5 functions are performed at least PARTIALLY (1 is absent) OR ALL 6 functions are performed with 4 or more PARTIALLY performed.	ALL 6 functions are performed, with up to 3 PARTIALLY performed.	ALL 6 daily team meeting functions are FULLY performed.
OS5	PROGRAM SIZE: The team is of a sufficient size to consistently provide for necessary staffing diversity and coverage. NOTE: This item includes separate parameters for minimal coverage for smaller teams to allow for enough staff to be available 24 hours a day, seven days a week.	100-Client 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-Client Team: Includes at least 10.0 FTE direct clinical staff.
		50-Client 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-Client Team: Includes at least 7.0 FTE direct clinical staff.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Operations and Structure (OS) Subscale (cont.)						
OS6	PRIORITY SERVICE POPULATION: ACT teams serve a specific, high service-need population of adults with serious mental illness and are able to make decisions about who is served by the team. (1) The team has specific admission criteria, inclusive of schizophrenia & other psychotic disorders or bipolar I disorder, significant functional impairments, and continuous high service needs, and exclusive of a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury or personality disorders. (2) The team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.	The team at least PARTIALLY meets criterion #2 only OR does not meet either criterion.	The team PARTIALLY meets criterion #1 only.	The 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.
OS7	ACTIVE RECRUITMENT: (1) The team (or its organizational representative) actively recruits new clients who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team. (2) The team is primarily comprised of clients from referral sources and sites outside of usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach). (3) The team works to fill open slots when they are not at full capacity and/or the client-to-staff ratio is well below 10:1 on more mature teams.	The team PARTIALLY meets 1 criterion or less.	1 criterion is FULLY met (2 are absent) OR 2 criteria met, with both criteria PARTIALLY met OR 1 criterion is PARTIALLY met and 1 FULLY met (1 is absent).	2 criteria are FULLY met (1 is absent) OR ALL 3 criteria are met, with 2 or 3 PARTIALLY met.	ALL 3 criteria are met, with 2 FULLY and 1 PARTIALLY met.	ALL 3 criteria FULLY met.
OS8	GRADUAL ADMISSION RATE: The team admits new clients at a low rate to maintain a stable service environment.	Highest monthly admission rate in the last 6 months is greater than 15 clients per month.	12 - 15	8 - 11	5 - 7	Highest monthly admission rate in the last 6 months no greater than 4 clients per month.
OS9	TRANSITION TO LESS INTENSIVE SERVICES: (1) The team conducts a regular assessment of the need for ACT services; (2) The team uses explicit criteria or markers to assesses 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) The team expedites re-admission to the team if necessary.	Up to 1 criterion is met OR 2 criteria are met, with 1 or 2 PARTIALLY met	2 criteria are FULLY met (3 are absent) OR 3 criteria are met, with 1 to 3 PARTIALLY (2 are absent).	3 criteria are FULLY met (2 are absent) OR 4 criteria are met, at least PARTIALLY (1 is absent).	4 criteria are FULLY met (1 is absent or only partially met).	ALL 5 criteria FULLY met.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Operations and Structure (OS) Subscale (cont.)						
OS10	RETENTION RATE: The team retains a high percentage of clients given that they enroll clients 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 client (e.g., activating a 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 client during their 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).	The team is involved in fewer than 15% of admissions & discharges.	The team is involved in 15% - 44% of admissions & discharges.	The team is involved in 45 - 69% of admissions & discharges.	The team is involved in 70% - 89% of admissions & discharges.	The 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 for the team, clients, natural supports, and other ancillary service providers (e.g., landlords, social security). Primary functions include the following: (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 clients and staff, such as attending to the needs of office walk-ins and calls from clients/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 rating "2" performance.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing 2 functions 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 2 functions.	1.0 FTE program assistance is available, at least PARTIALLY performing ALL functions.	1.0 FTE program assistance is available, FULLY performing ALL functions.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Team (CT) Subscale						
CT1	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, 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.	Less than 0.25 FTE team leader OR less than 0.75 FTE team leader with inadequate qualifications.	0.25 - 0.74 FTE team leader who meets at least minimal qualifications.	0.75 - 1.0 FTE team leader who does not meet minimal qualifications for education and experience.	0.75 – 0.99 FTE team leader who meets at least minimal qualifications OR 1.0 full-time team leader who meets all qualifications except having a clinical license.	1.0 FTE team leader who meets at least minimal qualifications, including licensure, and has full assigned responsibility to the team.
CT3	PSYCHIATRIC CARE PROVIDER ON TEAM: The team has at least 0.80 FTE psychiatric care provider time to directly work with a 100-client team. Minimal qualifications include the following: (1) Licensed by state law to prescribe medications, and (2) Board certified or eligible (i.e., completed psychiatric residency) in psychiatry/mental health by a national certifying body recognized and approved by the state licensing entity. For physician extenders, must have received at least one year of supervised training (pre- or post-degree) in working with people with serious mental illness.	Less than 0.20 FTE psychiatric care provider(s) per 100 clients.	0.20- 0.39 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients OR criteria for a "3" rating met, except communication standard if two or more providers. OR at least 0.20 FTE with inadequate qualifications cited.	0.40- 0.59 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients with demonstrated communication and collaboration if two providers. OR criteria for a "4" rating met, except communication standard if two or more providers.	0.60- 0.79 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients with demonstrated communication and collaboration if multiple providers OR criteria for a "5" rating met, except communication standard if two or more providers.	At least 0.80 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients. Two or more providers must demonstrate a mechanism for adequate communication & collaboration between/among providers.
CT4	ROLE OF PSYCHIATRIC CARE PROVIDER IN TREATMENT: In addition to providing psychopharmacologic treatment, the psychiatric care provider performs the following functions in treatment: (1) Typically provides at least monthly assessment and treatment of clients' symptoms and response to the medications, including side effects; (2) Provides brief therapy; (3) Provides diagnostic and medication education to clients, with medication decisions based in a shared decision- making paradigm; (4) Monitors clients' non-psychiatric medical conditions and non-psychiatric medications; (5) If clients are hospitalized, communicates directly with clients' inpatient psychiatric care provider to ensure continuity of care; and (6) Conducts home and community visits.	The 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 (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 performed.	ALL 6 treatment functions FULLY performed.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Team (CT) Subscale (cont.)						
CT5	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 client 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 the majority of treatment planning meetings; (4) Attends daily team meetings in proportion to the minimum time expected for caseload size; (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 clients' current status and medical records/current medications).	The 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.
CT6	NURSES ON TEAM: The team has at least 2.85 FTE registered nurses (RNs) assigned to work within a 100-client team. At least one full-time RN on the team has a minimum of one year of 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 item if the census goes even slightly above the 100-client team.	Less than 0.50 FTE RNs per 100 clients.	0.50 - 1.40 FTE RNs per 100 clients.	1.41 - 2.10 FTE RNs per 100 clients OR Criteria for "4" or "5" rating met, however 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 clients.	At least 2.85 FTE Registered Nurses (RNs) per 100-client team; 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	ROLE OF NURSES:The team nurses perform the following critical roles (in collaboration with the psychiatric care provider): (1) Manage the medication system, administer and document medication treatment; (2) Screen and monitor clients for medical problems/side effects; (3) Communicate and coordinate services with the other medical providers; (4) Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change); (5) Educate other team members to help them monitor psychiatric symptoms and medication side effects; and (6) When clients are in agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).	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 (1 is absent) OR ALL 6 functions are performed, but more than 3 are PARTIALLY performed.	ALL 6 functions, with up to 3 functions are PARTIALLY performed.	ALL 6 functions are FULLY performed.
Specialist Team (ST) Subscale						
ST1	CO-OCCURRING DISORDERS SPECIALIST ON TEAM: The team has at least one 1.0 FTE team member designated as a co-occurring disorders (COD) specialist who has at least a bachelor's degree and meets local standards for certification as a co-occurring specialist. Preferably this specialist has training or experience in integrated treatment for COD.	Less than 0.25 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE COD specialist with at least minimal qualifications.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Specialist Team (ST) Subscale (cont.)						
ST2	ROLE OF CO-OCCURRING DISORDERS SPECIALIST IN TREATMENT: The co-occurring disorders (COD) specialist provides integrated treatment for COD to ACT clients who have a substance use problem. Core services include the following: (1) Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health; (2) Assessing and tracking clients' stages of change readiness and stages of treatment; (3) Using outreach and motivational interviewing (MI) techniques; (4) Using cognitive behavioral approaches and relapse prevention; and (5) Applying treatment approaches consistent with clients' stage of change readiness.	The COD specialist provides 1 or fewer integrated treatment for co- occurring disorder services.	2 integrated treatment for COD services are provided (3 are absent).	3-4 integrated treatment for COD services are provided. (1 or 2 are absent) OR ALL 5 services are provided, with 3 or more services PARTIALLY provided.	ALL 5 integrated treatment for COD services are provided, but up to 2 services are only PARTIALLY provided.	ALL 5 integrated treatment for COD services are FULLY provided.
ST3	ROLE OF CO-OCCURRING DISORDERS SPECIALIST WITHIN TEAM:The co-occurring disorders (COD) specialist is a key team member in the service planning for clients with COD. The COD 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 co-occurring disorder assessment and treatment skills; (3) Attending all daily team meetings; and (4) Attending the majority of treatment planning meetings for clients with COD.	The COD specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.
ST4	EMPLOYMENT SPECIALIST ON TEAM: The team has at least 1.0 FTE team member designated as an employment specialist, with at least one year of experience providing employment services (e.g., job development, job coaching, supported employment). Ideally, the ACT employment specialist is a part of a larger supported employment & education (SEE) program within the agency.	Less than 0.25 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE employment specialist with at least minimal qualifications.
ST5	ROLE OF EMPLOYMENT SPECIALIST IN SERVICES: The employment specialist provides supported employment & education services. Core services include the following: (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.	The employment specialist provides 2 or fewer employment services.	3 employment services are provided (3 are absent) OR 4 services are PARTALLY provided (2 are absent).	4 employment services are provided (2 are absent), but up to 3 services are only PARTIALLY provided OR 5 employment services are provided (1 is absent) OR ALL 6 services are provided, with 4 or more PARTIALLY provided.	ALL 6 employment services are provided, but up to 3 services are only PARTIALLY provided.	ALL 6 employment services are FULLY provided

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Specialist Team (ST) Subscale (cont.)						
ST6	ROLE OF EMPLOYMENT SPECIALIST WITHIN TEAM: The employment specialist is a key team member in the service planning for clients who want to work or are currently working. The employment 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 & education approaches with clients in the team; (3) Attending all daily team meetings; and (4) Attending all treatment planning meetings for clients with employment goals.	The employment specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.
ST7	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 their own recovery; and (3) Has successfully completed training in wellness management and recovery (WMR) interventions.	Less than 0.25 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE peer specialist with at least minimal qualifications.
ST8	ROLE OF PEER SPECIALIST: The peer specialist performs the following functions: (1) Coaching and consultation to clients 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.	The peer specialist performs 1 or fewer functions on the team.	2 functions are FULLY performed (3 are absent) OR 2 to 3 functions performed, 1 to 2 PARTIALLY.	3 functions are FULLY performed (2 are absent or PARTIAL) OR 4 to 5 functions PARTIALLY.	4 functions are FULLY performed (1 is absent or PARTIAL).	ALL 5 functions are FULLY performed.
Core Practices (CP) Subscale						
CP1	COMMUNITY-BASED SERVICES: The team works to monitor status and develop skills in the community, rather than in-office. The team is oriented to bringing services to the client, 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.

ITEM		RATINGS / ANCHORS				
Core Practices (CP) Subscale (cont.)		(1)	(2)	(3)	(4)	(5)
CP2	ASSERTIVE ENGAGEMENT MECHANISMS: The team uses an array of techniques to engage difficult-to-treat clients. These techniques include the following: (1) Collaborative, motivational interventions to engage clients and build intrinsic motivation for receiving services from the team, and, where necessary, and (2) Therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to client 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 and #2 are 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)	A more limited array of assertive engagement strategies is used (PARTIAL #1 and #2).	Team uses #1 and #2 (at least 1 approach is FULLY used). Thoughtful application/ withdrawal of engagement strategies may be present or absent.	Team is proficient in assertive engagement strategies, including thoughtful application/ withdrawal of engagement strategies, applying all 3 practices.
CP3	INTENSITY OF SERVICE: The team delivers a 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.
CP4	FREQUENCY OF CONTACT: The team delivers a high number of face-to-face service contacts, as needed.	Average of less than 0.5 face-to- face contact / week or fewer per client.	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 client.
CP5	FREQUENCY OF CONTACT WITH NATURAL SUPPORTS: The team has access to clients' natural supports. These supports either already existed, and/or resulted from the team's efforts to help clients develop natural supports. Natural supports include people in the client's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy).	For less than 25% of clients, 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 clients, the natural support system is contacted by team at least 1 time per month.
CP6	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 clients in crisis 24 hours a day, seven 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 client; and (4) The team is able and willing to respond to crises in person, when needed.	Team has no responsibility for directly handling crises after-hours.	Team meets up to 2 criteria at least PARTIALLY OR criterion #1 is not met.	Team meets criterion #1 and at least PARTIALLY meets 2 to 3 criteria.	Team meets 3 criteria FULLY and 1 PARTIALLY.	Team FULLY meets all 4 criteria.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Core Practices (CP) Subscale (cont.)						
CP7	FULL RESPONSIBILITY FOR PSYCHIATRIC SERVICES: The team assumes responsibility for providing psychiatric services to clients, where there is little need for clients 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 clients 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 client is in a residential setting.	Less than 20% of clients in need of psychiatric services are receiving them from the team.	20 - 49% of clients in need of psychiatric services are receiving them from the team.	50 - 74% of clients in need of psychiatric services are receiving them from the team.	75 - 89% of clients in need of psychiatric services are receiving them from the team.	90% or more of clients in need of psychiatric services are receiving them from the team.
CP8	FULL RESPONSIBILITY FOR PSYCHIATRIC REHABILITATION SERVICES: These 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, environment, 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, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings. Psychiatric rehabilitation services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, and weekly client schedules).	Less than 20% of clients in need of psychiatric rehabilitation services are receiving them from the team.	20 - 49% of clients in need of psychiatric rehabilitation services are receiving them from the team.	50 - 74% of clients in need of psychiatric rehabilitation services are receiving them from the team.	75 - 89% of clients in need of psychiatric rehabilitation services are receiving them from the team.	90% or more of clients in need of psychiatric rehabilitation services are receiving them from the team.
Evidence-Based Practices (EP) Subscale						
EP1	FULL RESPONSIBILITY FOR INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: The team assumes responsibility for providing integrated treatment for co-occurring disorders (COD) services within the larger framework of integrated treatment for COD, where there is little need for clients 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). It is expected that the ACT COD specialist will assume the majority of responsibility for delivering integrated treatment for co-occurring disorders, but ideally other team members also provide some integrated treatment for co-occurring disorders services. Integrated treatment for co- occurring disorders reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of integrated treatment for COD are receiving them from the team.	20 - 49% of clients in need of integrated treatment for COD are receiving them from the team.	50 - 74% of clients in need of integrated treatment for COD are receiving them from the team.	75 - 89% of clients in need of integrated treatment for COD are receiving them from the team.	90% or more of clients in need of integrated treatment for COD are receiving them from the team.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Evidence-Based Practices (EP) Subscale (cont.)						
EP2	FULL RESPONSIBILITY FOR EMPLOYMENT AND EDUCATIONAL SERVICES: The team assumes responsibility for providing employment and educational (EE) services to clients, where there is little need for clients 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). It is expected that the ACT Employment Specialist will assume the majority of responsibility for delivering EE services, but ideally other team members also provide some EE services. Employment and educational services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of employment and educational services are receiving them from the team.	20 - 49% of clients in need of EE services are receiving them from the team.	50 - 74% of clients in need of EE services are receiving them from the team.	75 - 89% of clients in need of EE services are receiving them from the team.	90% or more of clients in need of EE 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 clients, where there is little need for clients to have to access such services outside of the team. These services include a formal and/or manualized approach to working with clients 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. WMR services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of WMR services are receiving them from the team.	20 - 49% of clients in need of WMR services are receiving them from the team.	50 - 74% of clients in need of WMR services are receiving them from the team.	75 - 89% of clients in need of WMR services are receiving them from the team.	90% or more of clients in need of WMR services are receiving them from the team.
EP4	INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: The TEAM practices from a model aligning with integrated treatment for co-occurring disorders (COD) where the TEAM (1) considers interactions between mental illness and COD; (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.	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met.	Team primarily operates from integrated treatment for COD, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team is fully based in integrated treatment for COD principles, FULLY meeting all 5 criteria.
EP5	SUPPORTED EMPLOYMENT AND EDUCATION (SEE): The TEAM practices from a model aligning with evidence-based supported employment and education (SEE) and the TEAM: (1) Values competitive work as a goal for all clients; (2) Believes and supports that a client's expressed desire to work is the only eligibility criterion for SEE services; (3) Believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment; (4) Believes and supports that placement should be individualized and tailored to a client's preferences; and (5) Believes that ongoing supports and job coaching should be provided when needed and desired by client, and has provided such supports.	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met.	Team primarily embraces SEE, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team fully embraces SEE and FULLY meets all 5 criteria.

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Evidence-Based Practices (EP) Subscale (cont.)						
EP6	ENGAGEMENT & PSYCHOEDUCATION WITH NATURAL SUPPORTS: The FULL TEAM works in partnership with clients' 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 clients' natural supports.	1 or 2 services are provided.	ALL 3 services are provided, but 2-3 strategies only PARTIALLY.	ALL 3 services are provided but 1 only PARTIALLY.	ALL 3 services are FULLY provided by team.
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 clients in need of such services. Although all team members can be trained to effectively use therapeutic techniques, such as cognitive behavioral therapy and motivational interviewing, the team also ideally has a licensed therapist.	Team does not provide psychotherapy to clients. No criteria are met.	1 to 2 criteria are PARTIALLY met.	Criterion #1 is PARTIALLY met and criteria #2 and #3 is at least PARTIALLY met. OR Team FULLY meets both criteria #1 and #2, but does not meet criterion #3.	Team FULLY meets criterion #1, PARTIALLY meets criterion #2, and at least PARTIALLY meets criterion #3. OR Team FULLY meets both criteria #1 and #2 and only PARTIALLY meets criterion #3.	Team FULLY meets all 3 criteria.
EP8	SUPPORTIVE HOUSING: The team embraces supportive housing, including: (1) assisting clients in locating housing of their choice (e.g., providing multiple housing options, including integrated housing); (2) respect for clients' privacy within residence; (3) assistance in accessing affordable, safe/decent, and permanent housing; and (4) assured ongoing tenancy rights, regardless of clients' 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.
Person-Centered Planning & Practices (PP) Subscale						
PP1	STRENGTHS INFORM TREATMENT PLAN: (1) The team is oriented toward clients' strengths and resources, and (2) clients' strengths and resources inform treatment plan development.	Strengths are not assessed (no criteria #1).	Team variably attends to clients' strengths and resources and strengths/ resources do not inform planning (Partial #1 only).	Team is clearly attentive to clients' strengths and resources, but clients' strengths and resources do not typically inform plan development (Full #1 and No credit #2) OR Team is variably attentive to strengths and uses this information to inform plans, but less systematically (Partial #1 and Partial #2).	Team is clearly attentive to clients' strengths and resources, which informed plan development for some (Full #1 and Partial #2).	Team is highly attentive to clients' strengths and resources, and gathers such information for the purpose of treatment planning (Full #1 and Full #2).

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Person-Centered Planning & Practices (PP) Subscale (cont.)						
PP2	PERSON-CENTERED PLANNING: The team creates treatment plans using a person-centered approach, including: (1) Development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting) and with the team, preferable the individual treatment team (ITT); (2) Conducting regularly scheduled treatment planning meetings, (3) Attendance by key staff (i.e., members of the ITT), the client, and anyone else they prefer (e.g., family), tailoring number of participants to fit with the client's preferences; (4) Provision of guidance and support to promote self-direction and leadership within the meeting, as needed; and (5) Treatment plan is clearly driven by the client's goals and preferences.	No more than 1 function of person- centered planning is performed OR 2 functions are performed, but not fully.	2 functions of person-centered planning are FULLY performed (3 are absent) OR 3 functions are performed at least PARTIALLY (3 are absent).	4 functions of person-centered planning are performed (1 absent) OR 5 functions performed, with 3 or more PARTIALLY performed.	ALL 5 functions of person-centered planning are performed, with up to 2 PARTIALLY performed.	ALL 5 functions of person-centered planning are FULLY performed.
PP3	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 clients' needs.	The team does not plan for and/or deliver interventions that reflect a breadth of life domains.	Team minimally plans for and/or delivers interventions that reflect life domains (PARTIAL credit for one criterion only) OR Team plans for but does not deliver a breadth of services (Full #1 only).	Team plans for and delivers interventions that reflect a breadth of life domains, but less systematically (PARTIAL #1 and PARTIAL #2) OR a larger breadth of services are planned for, but not in turn delivered (FULL #1 and PARTIAL #2).	Team delivers interventions that reflect a range of life domains to all clients (FULL #2), but interventions targeting a breadth of life domains are not systematically specified in treatment plans (PARTIAL #1 OR FULL #1, but lacking Alignment).	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 Alignment).
PP4	CONSUMER SELF-DETERMINATION & INDEPENDENCE: The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients, level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.	None of the 3 practices are employed OR only 1 is employed (FULLY or PARTIALLY).	2 practices are employed (FULLY or PARTIALLY), with 1 absent.	3 practices are employed, with 2 to 3 PARTIALLY.	Team generally promotes clients' self-determination and independence. All 3 practices are employed, but 1 PARTIALLY employed.	Team is a strong advocate for clients' self-determination and independence. All 3 practices FULLY employed.